An Exploration Of The Development Of Resilience In Student Midwives.

Thesis

An exploration of the development of resilience in student midwives

by

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Glossary

Empowerment - a psychological process, which enables an individual to establish and attain their defined goals (Collins Dictionary, 2015).

HEI - Higher Education Institution. All UK midwifery programmes are undertaken in universities, referred to as HEI's.

'Home and Away' – 'Home' is the NHS Trust where the allocated students spend their first and third year placements. 'Away' is a different Trust for placement in the second year.

LME - Lead Midwife for Education.

Psychoticism - a third major dimension of personality. A state where individuals display features in certain environments that are commonly found amongst psychotics (Eysenck, 1992).

Reflection - the process of deeply considering an event in order to develop knowledge and understanding to improve one's own practice.

Reflexivity - the ability of the student midwife to examine their own feelings, reactions and motives regarding midwifery and how they inform their practice as a midwife (adapted from http://dictionary.cambridge.org/dictionary/reflexivity (accessed 13/8/19).

Research Reflexivity - paying attention and thinking about each stage of the research process. Considering the impact of the researcher's own beliefs and opinions on the research outcomes and on the researcher, both personally and professionally.

The Nursing and Midwifery Council – the regulatory body for nurses and midwives. Conjointly approves programmes with the Higher Education Institution.

Abstract

Student midwives have to complete a demanding programme to become a midwife, and therefore it is questioned whether they need resilience to be successful. The study's aims were to explore whether resilience developed in one cohort of 25 undergraduate student midwives and what the concept of resilience meant to them. This study adopted a longitudinal case study approach, in one Higher Education Institution (HEI) in England, during the first 18 months of their programme. The study used Wagnild and Young's (1993) (updated 2015) True Resilience Scale©, administered on three occasions. Additionally, four focus groups were conducted twice and six participants were involved in one-to-one interviews, to explore issues raised in the focus group.

Version 24 of the Statistical Package for the Social Sciences (SPSS) was used to analyse the findings of the True Resilience Scale©. Pairwise comparisons revealed that there were significant differences in True Resilience Scale© scores between the first and the second completion ($p= 0.034$) and time 1 and time 3 ($p= 0.002$); there were no significant differences between time 2 and time 3 ($p=1.0$). In this cohort of student midwives the scale showed that the majority had developed their resilience during the study.

The qualitative data were thematically analysed using Braun and Clarke's (2013) stages. The participants described themselves as developing resilience despite the programme being very hard. They believed that being passionate about midwifery, being adaptable and learning from reflection was key to being resilient as a student midwife. The importance of support and belonging in clinical practice and their mentors were key to success. Despite the challenges they

encountered on the programme, they felt supported and prepared to become midwives.

A model, which defines resilience for student midwives, is presented for consideration in midwifery curricula to strengthen how reflexivity is taught and supported.

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To Karen Cooney who has supported me to get over the final hurdle of submission – your sense of humour and sharp eye were invaluable.

To my husband and children: thank you for your patience and support. I hope that the completion of my doctorate in education will make you proud and be inspired.

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Chapter 1.0 Introduction and background

1.1 Introduction

Retention on midwifery undergraduate programmes has been termed the '*wicked problem'*, as there is no simple solution. The '*wicked problem'*, first described by Rittel and Webber (1975:155), is a complex problem and one that may never be completely addressed. The reasons why students leave a midwifery programme are multifactorial; therefore, trying to determine the experiences of student midwives on undergraduate programmes is crucial in order to address the high attrition rates and the loss of good quality students to the midwifery profession. In my experience, some midwifery students have a number of personal difficulties during the three-year programme; some carry on whilst others request an interruption from studies in order to deal with their personal circumstances.

Recent research has considered whether resilience is the key to being a successful midwife and to preventing attrition from the profession (Hunter and Warren, 2013). To date there has been no published research focusing purely on the concept of resilience amongst student midwives and the role it might play during the midwifery programme. Additionally, an unanswered question is whether resilience is the key to students remaining on an undergraduate midwifery programme. Although there is a scarcity of literature in respect of resilience and student midwives, sessions exploring the trait have been introduced to healthcare programmes (Rogers, 2016) so it is important to understand what may be helpful for midwifery programmes.

The title of '*midwife*' and function of a midwife is protected in law (NMC, 2018a). At the point of registration, the midwife's role is to provide midwifery care as an autonomous, accountable practitioner with a unique body of knowledge (ICM, 2018; RCM, 2018a). The scope

of practice means that a midwife works autonomously and independently at the point of registration and has full responsibility for their caseload. The midwife promotes and advocates for non-intervention in normal midwifery and will collaborate and consult with other healthcare professionals only when there is a requirement to meet the needs of the woman, her newborn and family. Student midwives will be prepared to take on this responsibility by observing midwives' practice during their clinical placements. Nevertheless, for some students the realisation of the responsibility can be quite daunting. Arguably student midwives require particular personal attributes to be able to undertake the role, with resilience being one of them.

This research study investigated the development of resilience in student midwives during the first 18 months of their programme, using a case study approach. The primary aim of the study was to use a well-validated resilience scale to determine whether or not resilience developed during 18 months of the study period. Additionally, focus groups and one-to-one interviews were used to further explore the student midwives' views on their resilience and its relevance the programme.

In this chapter, a brief introduction to the definition of resilience from non-healthcare literature is given and discussed. Background information about the context of midwifery undergraduate programmes is given, plus the research questions and an overview of the thesis by chapter are also detailed.

1.2 Overview of the concept of resilience

Ahern et al (2015) conducted an integrative review of the empirical literature published between 2000 and 2015. In reviewing over 100 articles they found no universal definition of resilience.

McAllister and McKinnon (2009:373) proposed that resilience is reflected by an individual having:

> *'An internal locus of control, pre-social behaviour, empathy and the ability to organise daily responsibilities ….in addition, resilient individuals appear to be more adaptable to change…'*

Santos (nd:1) suggested that resilience is the ability to bounce back after *'some form of disruption, stress or change'*.

Some research suggests that individuals who are resilient could be described as '*hardy'*, '*invulnerable'* or '*invincible'* (Werner, 2012). However, other researchers have suggested that resilience is something that develops within individuals (Masten, 2001). This is of particular interest to this study.

Ungar (2008:225) defined resilience as:

> 'the context of exposure to significant adversity whether psychological, environmental or both, resilience is both the capacity of individuals to navigate their way to health-sustaining resource, including opportunities to experience feeling of well-being. And a condition of the individual family, communities and culture to provide these health resources and experiences in culturally meaningful ways.'

Masten (2001) believed that everyone has an innate capacity for resilience, which will develop when the conditions are right. Denz-Penhey and Murdoch (2008) considered that resilience requires four dimensions of connectedness as well as a supportive mind-set. In contrast, Antonovsky (1987) proposed that individuals need coherence

through meaningfulness, manageability and comprehensibility to cope in times of stress. Additionally, the literature also advocates that individuals can be resilient at certain times but not at others. This implies that people may also react differently at various times in their lives, suggesting that resilience is a dynamic process (Masten and Tellegan, 2012; Santos, nd).

Although the word '*resilience*' is currently in popular use, there has been over fifty years of research undertaken in this area. Masten and Wright's (2010:214) review of resilience research considered that it has moved through four phases and that current work is focused around '*integrative ways to better understand the complex processes that lead to resilience'*. This is illustrated in a discussion, following these authors' literature review, about whether resilience is an inherited personal characteristic or a trait that develops as a result of external stressors (Ahern et al, 2015).

Masten and Obradovic (2006) provided a useful review of the history of the three waves of resilience reliance, highlighting that the concept was originally aligned to the fields of medicine, psychology and education. The initial early research, which was largely descriptive, considered how children positively adapted despite their genetic and environmental risks, presenting a list of potential assets or protective factors associated with resilience. Subsequent research explored what structures and systems may affect the proposed assets and protective factors.

The literature is complex regarding what risk factors may affect a person's resilience. Condly (2006:225) argued that as risk is '*multifaceted*' then this might also be the case with resilience. Rutter (2006) considered that the term resilience is used to describe individuals who, despite being subjected to challenging experiences,

do not suffer long-term consequences. Rutter proposed that by becoming resilient, the individual undergoes some '*physiological adaptation, psychological habitualisation, a sense of self-efficacy, the acquisition of effective coping strategies and/or a cognitive redefinition of the experience'.* (Rutter 2006:2). This author grouped the research evidence into two distinct areas, namely that people respond very differently to various environmental adversities and that, for some, the experience of adversity can strengthen their resistance against future challenges. However, Rutter (2006) considered that the origin for the resilience could be due to the variation in the risk experienced. Therefore, this author concluded that resilience is not a '*single quality'* or constant. This appears to be due to the variability in outcome even when people are exposed to the same hazards (Rutter 2006:6).

This study explored whether the definitions of resilience found in the literature could be applied to what was being experienced by student midwives, hence adding impetus to this study to explore the concept.

1.3 Rationale for the research study

In my previous role as a Programme Leader for an undergraduate midwifery programme, I dealt on a day-to-day basis with the issues that student midwives are facing while on the programme. I had observed that the students who commenced the programme were both enthusiastic and motivated to be midwives, having secured their places on the programme through a very competitive selection process. They had been briefed at various stages along the selection process that the programme is a challenging one, not least because they had to succeed both academically and in clinical practice. Fifty percent of the midwifery programme is spent in clinical practice in National Health Service (NHS) settings and they are expected to work full time hours (NMC, 2009). Once on the programme, however, some described how they found the programme did not meet their expectations and that it

was not the right career choice. Others had personal issues, which necessitated an interruption from the programme and some then did not return.

It is very costly to lose a student midwife, not only to the HEI but also to the NHS; however, there is little research into institutions that try to manage the whole '*basket*' of risk factors in a holistic way to achieve lower attrition rates (DH, 2006:4). It has been argued that there are limited data that detail the factors that lead to both attrition and retention (Green and Baird, 2009). These authors conducted research that compared a three-year and a 78-week midwifery programme and found that there were very few cases where there was only one reason to explain why a student midwife left the programme. They argued that the students' motivation at the start of the midwifery programme needed to be nurtured to avoid it declining as they progressed on the course.

Health Education England (HEE) recently published a report on attrition and retention in the healthcare professions (Lovegrove, 2018). Between the academic years of 2009/2010 and 2014/2015 the average attrition rate for midwifery students was 13.6% with a rate of 15.9% being the highest rate during that period. Retention theories have cited persistence, resilience, self-efficacy and belongingness as the key features that an individual needs if they are to complete their programme. For example, Glogowska et al (2007) identified '*push*' factors, which made it difficult for student nurses to remain on the programme, and '*pull*' factors that enabled them to persist. The '*push*' factors were academic challenges, financial issues, illness and poor experiences in clinical practice. In contrast the '*pull*' factors included determination, commitment to the profession and support from both formal and informal sources. Nursing students who are more mature, namely, 25 years of age and over, have been found to be more likely to

complete the programme. The possible reasons cited were increased motivation and resilience (Pryjmachuk et al, 2009). Additionally, students have also been described as becoming disillusioned with the programme, citing that they have not made the right career choice and with the reality of nursing not living up to their expectations (O'Donnell, 2011; Pryjmachuk et al, 2009).

Although the term resilience was not discussed, Enoch et al's (2013) research found that medical students who are not coping on their programmes expressed feelings of being burnt-out, overloaded and depressed. In contrast, other studies have found that students with resilience have fewer mental health problems and are better able to adjust to being at university (Hjemdal et al, 2006; Stallman, 2011). Students with high levels of resilience are also reported to have fewer psychological issues and higher levels of mindfulness (McGillivray and Pidgeon, 2015).

Resilience has been considered a key personal characteristic of a healthcare professional able to cope with the demands of their chosen profession (Grant and Kinman, 2014). There is an increasing amount of literature which suggests that if students were to be equipped to be resilient they would be able to cope better with their undergraduate programmes (McGillivray and Pidgeon, 2015). McGillivray and Pidgeon (2015) support the promotion of protective resilient interventions, such as the use of mindfulness or meditation techniques, within undergraduate programmes.

Promoting resilience therefore assumes that it is a tangible trait that could be measured; however, overall the literature does not support this. It could be argued that whilst the idea that sessions on resilience will satisfactorily prepare students for what they will face in their daily

lives as healthcare practitioners is appealing, it is also a somewhat naïve approach.

The discussion within the literature about resilience raises the question of its significance to student midwives and whether the definition within the literature can be applied to them. The rationale for this study is that there is a paucity of research that has considered resilience in midwifery and none has been found that has studied student midwives. Hunter and Warren's (2013) research, '*Investigating resilience in midwifery*', was key to increasing an understanding about resilience in registered midwives who are working in the NHS. It could be suggested that resilience as a concept is difficult to define and may take on different meanings depending on the context, in this case midwifery undergraduate students. As to date there has been no research that has investigated resilience in student midwives while on their undergraduate programme, there was justification for this study. Additionally, with current midwifery shortages (RCM, 2018b) the effect that resilience might have on students to promote them joining the midwifery profession seemed important. The context of midwifery programmes will next be explored to set the scene for the study and give the reader greater insight into the current demands placed upon students.

1.4 The current UK context of midwifery programmes

Prior to 1992, midwifery training was delivered in the NHS Schools of Midwifery based within hospitals. The intakes were made up of a ratio of teachers to learners, approximately 1:20. Teaching sessions were arranged within the departments using dedicated teaching spaces. As the maternity wards were on site, a number of teaching sessions could be held in the clinical maternity setting. There was no academic award attributed to the programme as it was purely a professional

qualification, enabling the successful completers to register with the regulatory body and to practise as qualified midwives.

The move into higher education in the early 1990s brought many changes to the midwifery programme. A direct entry route was developed whereby students with the appropriate entry qualifications, but not those who were already a registered adult nurse, could enter onto a three-year course and be awarded on completion with either a diploma or an honours degree. By 2006, the diploma route had ceased to exist so that the profession could become all-graduate. The cohorts became larger and both the universities and the professional regulatory body regulated the programmes.

Midwifery in the United Kingdom (UK) is a three-year, full time, undergraduate programme awarded with a minimum of a bachelor's degree (NMC, 2009). More recently a graduate entry route has been developed for candidates already with a university degree; the academic award after three years is at master's level. The students who successfully complete the pre-registration midwifery programme are eligible to register with the Nursing and Midwifery Council (NMC) and are able to practise as a registered midwife in the UK. Therefore, the programmes are complex in that they must meet both the HEI's and regulatory body's requirements.

The programme is planned so that 50% of the time is theory and the other 50% is spent in clinical midwifery practice. Midwifery programmes are very practice focused because the students are being prepared for their role as midwives and they require many skills to equip them for practice. There is no compensation allowed within the modules; all must be passed. There are relatively small numbers of students per intake, for example a range of 25-55. All midwifery programmes have to be NMC approved and this includes a fixed set of

modules that must be completed, taking away student choice. A further restriction is that the regulatory body determines that there must be an exam within the programme (NMC, 2009). Fifty percent of all grades across the programme are gained from the clinical placements; therefore this puts a lot of pressure on students, additional to learning clinical skills. Also, there is no compensation rule allowed in the midwifery programme, which means that passes in all assessments have to be achieved (NMC, 2009).

The NHS paid fees and bursaries until the academic year 2017/2018 in England when a new funding arrangement brought healthcare students in line with other students. This change has meant that midwifery students are now required to secure a student loan for course fees and living expenses. The change in funding arrangements has placed an additional stress on programmes, resulting in an adverse effect on recruitment and retention (RCM, 2017a). The change in funding arrangements could mean that the concept of resilience has greater prominence for future student midwives, making the need to study the concept with this group of healthcare students more pressing.

Midwifery students are effectively completing a degree at the same time as training to be midwives. Their programme year is 45 weeks in length, longer than students undertaking non-healthcare degrees, and does not have the traditional long summer break. They have to work full time in clinical practice in order to meet their competencies and work the full range of shifts including long days, nights, weekends and public holidays. The programme has many competing elements and requires students to be both resourceful and determined in order to complete the course. On the other hand, unlike many graduates, midwifery students are prepared to secure employment on completion of their degree and some universities cite employment rates of around

99%[1] within six months of qualifying. Nevertheless, this in itself may not be a sufficient incentive to complete the programme. Some reasons for not completing the programme could be the negative experiences midwives are exposed to in practice, including staff shortages (RCM, 2017a).

In addition to these contextual factors regarding midwifery programmes, the midwifery profession is facing many challenges following the failings in maternity services as highlighted in the Kirkup report (2015). As a result, the profession is now undergoing unprecedented change in terms of both regulation and delivery of maternity care (NMC, 2015; Cumberlege, 2016). Student midwives are inevitably going to be affected by such changes and will potentially need to develop skills to be able to cope. It follows that the need to understand the role that resilience might play for student midwives in enabling them to successfully navigate the undergraduate midwifery programme makes this research study of significance. It is also proposed that a definition of the concept of resilience for student midwives is required.

1.5 Research questions

Due to the paucity of research and a gap in the literature in relation to student midwives and resilience, an exploration of the key issues was identified as warranted. The two overarching research questions for this study are:

1. How do student midwives recount their understanding of resilience in relation to the midwifery undergraduate programme?

[1] Personal review of universities' websites offering a midwifery programme.

2. To what extent is the development of resilience in the first 18 months of a three-year undergraduate midwifery programme a factor in a student's ability to navigate the undergraduate midwifery programme?

The study's research sub-questions are:

(a) What characteristics are evident in student midwives who describe themselves as resilient?

(b) What strategies do students adopt who describe themselves as resilient?

1.6 Structure of the thesis

This thesis comprises six chapters:

Chapter 1: Introduction and background

The introduction sets the scene, rationale and justification for the research study. Resilience as a term in common use has been explored along with its potential application to student midwives. The context of midwifery education today is detailed to provide an appreciation of the differences between studying for a midwifery degree and one not related to healthcare.

Chapter 2: Literature review

A literature review was conducted to determine the existing knowledge base about resilience and student midwives. Extensive literature about the concept of resilience *per se* has been identified but there has been a paucity of literature in relation to student midwives. The gaps in the literature confirmed the relevance of the research questions for the study.

Chapter 3: Methodology, research design and methods
This research study has aligned itself to case study research, examining participants in one cohort of student midwives for the second 18 months of their three-year undergraduate programme. The study combined findings from the use of a resilience survey tool, known as The True Resilience Scale©, with focus groups and one-to-one interviews. The data were gathered from the three sources, in different collection periods, with each being analysed individually. The True Resilience Scale© has been descriptively analysed and the results put through SPSS version 24.

Chapter 4: Findings
The findings of the administration of the True Resilience Scale© on three occasions are described. The trends in the True Resilience Scale© scores over the 18-month period are also presented. An account of the collated findings of the eight focus groups and six one- to-one interviews is also given. Direct quotations from the participants are included throughout the chapter.

Chapter 5: Discussion
The findings of the study are discussed in this chapter in the context of the existing research and literature. The potential implications for future student midwives in respect of the concept of resilience are explored.

Chapter 6: Conclusions, reflections, implications and recommendations
The implications of the study for midwifery education are considered and the overall conclusions and recommendations presented.

1.7 Conclusion

This research study has explored what the concept of resilience means to student midwives. It also considers the role that resilience might play in supporting the students to complete the first 18 months of their midwifery programme and whether resilience develops or not during this period. The study examines the experiences of contemporary student midwives and what influences them remaining on the programme to become qualified midwives. The first task involved undertaking a literature review. This review assisted in understanding the gaps in the literature and the current theoretical and political contexts.

Chapter 2.0 Literature review

2.1 Introduction

The literature on resilience is vast and spans all age groups and circumstances, for example, children in care and adults with an illness. To date, there remains a paucity of literature specifically studying student midwives. Therefore, for this critical review, there was a need to have clear inclusion and exclusion criteria to ensure that the literature selected was pertinent to midwifery students. The review included papers that considered resilience in qualified nurses and midwives as well as healthcare students. The review wanted to ascertain whether there were any transferable findings in the literature that could be applied to midwifery students and significant to this research.

2.2 Search strategy

The primary literature review was performed between May and November 2015. The literature review strategy drew on five databases being searched, namely: Medline, Education Research, Complete, Cumulative Index of Nursing and Allied Health Literature (CINAHL), British Education Index, and Midwives Information and Resource Service (MIDIRS). Key words were used in a variety of combinations along with the Boolean operators AND/OR to expand the search. Table 1 details the key words and number of hits achieved from each of these databases.

Database	Key words / phrases using Boolean principles	Total references identified	Articles exclude	Articles retained for full review	Articles rejected after full review
Medline No papers overlapped	Resilience + healthcare + students	10	0	10	0
	Resilience + healthcare + professional	38	0	38	0
	Resilience + midwifery + students	11	0	11	0
	Resilience + coping + students	61	0	61	10
	Emotional intelligence + midwifery	0	0	0	0
Education Research Complete Same papers found	Resilience + healthcare + students	7	0	7	0
	Resilience + healthcare + professional	7	0	7	0
	Resilience + midwifery + students	7	0	7	0
	Resilience + coping + students	7	0	7	0
CINAHL	Emotional intelligence + midwifery	1	0	1	1
	Resilience and midwifery	33	0	0	0
	Resilience and undergraduates	8	0	2	0 All 8 overlapped with Medline

Table 1: Databases and search strategy

Inclusion criteria	Exclusion criteria	Rationale
Papers published between 2005-2015	Papers published prior to 2005	Papers that were published in the previous 10 years to ensure currency
Western papers written in English, from United Kingdom, Australia, New Zealand and Canada	Papers not written in English or in United Kingdom, Australia, New Zealand and Canada	Nursing and midwifery practice is similar to UK
Literature reviews, original research, discussion papers, grey literature	None	To consider how resilience is being discussed in a range of literature
Healthcare students and qualified healthcare staff	Papers written for non-healthcare audiences	To have potential applicability to midwifery students

Table 2: Literature search inclusion and exclusion criteria

The inclusion and exclusion criteria for the papers reviewed are listed in table 2 above. To ensure the most recent research was referred to, the review of the literature was, where possible, restricted to the last ten years, namely 2005 to 2015. There were a number of older research papers, which had not been replicated and, therefore, it was felt important to consider these for inclusion, particularly in relation to definitions of resilience. Literature relating to nursing and healthcare professionals was included for critical review, as it was felt this focus would align to student midwives and be applicable to midwifery. The search was restricted to published papers, written in English, in the United Kingdom, Australia, New Zealand and Canada where nursing and midwifery practice has similarities in terms of scope of practice. One paper from the Netherlands was felt to be relevant. Another paper felt important to include, although not directly related to healthcare students, as it was a large study, across five continents and 14 countries, extensively explored the definition of resilience amongst

youths (Ungar, 2008). This paper was felt to be rigorous and the youths had some applicability to the age of midwifery students.

Research studies, literature reviews and policy papers were reviewed and included; only one paper of relevance in the grey literature was found during the literature search. First, the abstracts were read to screen for the relevance of the paper and to ensure that they met the inclusion criteria. The full text of the relevant papers was gained, read and critiqued. Further papers that were referred to in the text and were considered as possibly relevant were accessed through back-chaining.

When reading the papers, the Critical Appraisal Skills Programme (CASP, 2018) checklist was used to determine the quality of the qualitative papers. Papers that were felt to lack focus directly to the topic or were of poor quality were discarded. This process ensured that the final papers that were selected for inclusion in the literature review were directly relevant and were of sound quality. A total of 34 papers were found to be relevant and have been included in the critical review; some additional papers have been included that inform the discussion of the chapter but have not been critiqued in depth. The key research papers included in the literature review were all summarised and documented in a table (see appendix 1).

Subsequent to the initial literature search period, alerts were set up through CINAHL and MIDIRS to ensure that any new published research was identified. A further eight studies were published between November 2015 and November 2018 that met the inclusion and exclusion criteria. It was felt to be inappropriate to add the more recent papers to the original literature reviews. These have been presented and critiqued in a separate section at the end of this

chapter. The more recent literature played a key role in supporting the on-going discussion of the study's findings in chapter 5.

2.3 Themes from the literature search

This review first explored how resilience was defined in the literature and in what circumstances the term was used. The literature offered a variety of definitions for the concept of resilience, these were examined and their relevance to student midwives considered. Secondly, as many papers explored how resilience can be promoted, it was considered a key theme to present. Thirdly, the concept of emotional intelligence was frequently discussed alongside resilience and it was felt, therefore, that the two terms needed to be compared and contrasted. Fourthly, the characteristics of a person, in terms of them being resilient, were reviewed, particularly in the context of whether this has an impact on a healthcare student remaining on the programme; whether these had any relevance to student midwives was reviewed. Finally, the literature described both positive and negative features in clinical practice settings and how this affected the experiences of healthcare students and the role resilience played.

In summary, the five main themes that emerged from the literature and structured this literature review are:

1. Towards a definition of resilience
2. The promotion of resilience
3. Emotional intelligence and resilience
4. Factors and attributes affecting the completion of the programme
5. Resilience and the effect of the clinical practice setting.

Each of these themes are presented in turn, starting with how the literature defines resilience.

2.4 Towards a definition of resilience

There is disagreement in the literature on how to define resilience and there are many definitions on offer describing it both as a genetic component and a trait developed as a result of significant childhood experiences. In Masten's (2001:228) review of the definitions and models of resilience, resilience was also viewed as being present within individuals if there had been a significant threat to their development through '*current or past hazards*'. Masten (2001:228) suggested that resilience is an '*inferential*' and '*contextual*' construct, meaning that to be resilient the individual needs to have experienced significant threat to their development. Masten (2001) suggested that resilient individuals are viewed in the literature as possessing certain characteristics and that everyone has an innate capacity for resilience, developing when the conditions are right. Masten (2001) observed that the resilience research demonstrated it being an ordinary process, which results from normal human adaptation. There have been two approaches to resilience research, namely, variable-focused and person-centred. Variable-focused research uses multivariate statistics considering the personal qualities of the individual to test for links between the measures, to ascertain the connection between the degree of risk or adversity and outcome. Masten (2001) considered that there was little evidence, from this research, that severe adversity has major lasting effect on the adaptive behaviours unless cognition or parenting was lacking.

Person-centred approaches focused on the whole individual, trying to assess how adaptation is occurring to be able to organise it into patterns. Masten (2001) expressed concern about the generalisability of this approach, particularly where single case studies are used. Similarly what is also missing from the literature are low risk groups and whether resilient children differ from children who are doing equally well but do not have high-risk factors.

Therefore, Masten (2001) concluded from the evidence that there are a number of factors that are associated with resilience. These include the carers of the children, as well as self-regulation and positive views of self, which promotes ordinary human adaptive processes. The question is whether the research that Masten discussed can be applied to adults, as much of it was carried out with children. The challenge is to determine whether the risks quantified by Masten are the same in intensity and are they different in the midwifery context.

Resilience is also reported in the literature as being the ability for individuals to '*bounce back'* after some form of disruption, stress or change. Garcia-Dia et al (2013:267) systematically analysed the promotion of resilience through an integrated review of the literature. They found that resilience was discussed as the ability to '*bounce back'* following adversity and is a dynamic process with the environment, external factors and the individual affecting its promotion. Garcia-Dia described how, in their work, nurses witnessed tragedy, suffering and human distress and felt that the development of resilience was imperative. The challenge these authors faced was that resilience is difficult to measure and define and that there are only a few measures for adults; Wagnild and Young's (1993) resilience scale was cited. Despite this, Garcia-Dia et al's (2013:266) review of the literature was not able to locate a scale that directly measured the attributes of resilience they identified in their discussion, namely: '*rebounding, determination, social support and self-efficacy.'*

Ahern (2006), using 22 articles in relation to the adolescent population, highlighted that the aspects of resilience were studied in two main ways, namely, psychological and physiological. Ahern found in a review of the literature that the early studies of resilience focused on the factors and characteristics that support an individual to thrive despite adversity. However, Ahern (2006) suggested that individual

and environmental factors should be recognised and how they interplay are also important for resilience. Additionally, the variability of resilience in adolescents, Ahern proposed, was due to an individual's stage of development and defined resilience as the relationship between the personal characteristics and factors in the environment, leading the individual to have the ability to cope and adapt when faced with adversity. Therefore, being resilient could be suggested as healthy for an individual. A number of characteristics appear to be significant including: self-esteem, connectedness, self-control, hardiness, survival and adaptive (Ahern, 2006). Although these characteristics appear to have application to midwifery, it could be argued that the challenge is that we do not know what factors are key for any one individual. It also raises the question that the resilience factors might vary between individuals.

Ahern (2006) concluded that resilience research was moving away from its focus on attributes, to considering which processes may promote resilience when conditions are adverse. This author suggested that there was confusion about a global definition of resilience in adolescents and that increasingly the research was focusing purely on healthy adults and how they deal with stressful conditions, rather than those with a range of different needs.

Ungar (2008:167) described resilience as sustaining well-being, with the individual having the capacity to draw on '*psychological, social, cultural and physical resources*'. Ungar (2008) carried out extensive research using a mixed-methods investigation across five continents, in 14 countries, involving 1500 youths. Ungar (2008:225) considered resilience as being:

> *'in the context of exposure to significant adversity whether psychological, environmental or both, resilience is both the capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience a feeling of well-being.'*

Student midwives need to be able to continue on their programme without allowing the events they experience in practice to affect their personal well-being. Ungar's work was in relation to children and young people and may not necessarily be applicable to adults. Nevertheless, Ungar's suggestion that resilience is the ability of individuals to return to well-being could be useful to better explain what happens to midwifery students who cope with the programme even when they face difficulties. Although student midwives are exposed to challenging situations, it could be argued that this does not consistently reflect the '*significant adversi*ty' that Ungar suggests. Nevertheless, the reality of a student midwife navigating the programme and developing resources to retain their well-being for midwifery practice does have resonance. Ungar's principles could be applied to midwifery with there being a place for resilience to be nurtured in the undergraduate midwifery programme.

If resilience is to be viewed as important to midwifery, and particularly to student midwives, then a clear definition and how to recognise it is important within maternity care. Reyes et al (2015) also argued that the clinical placement areas were the cause of most stress and adversity for students in their programme, therefore, it was important to develop resilience. Reyes et al (2015) used an integrative review method to analyse and synthesise the literature they reviewed on resilience in nursing education. They found some recurring themes in the literature following their analysis of the term resilience, namely that resilience was important for nurse education, it is conceptualised

as neither a trait nor a process and it is related to protective factors to cope with stress and adversities (Reyes et al, 2015:438). These authors concluded that resilience was not a static process but one in which the individual developed personal protection against adverse situations by persevering and being active in their response to challenges and this was a dynamic changeable phenomenon involving growth and development. Resilience was also cited as being important in cultural adaptability. Resilience was demonstrated through the students' perseverance with the challenges they faced and was an important factor in affecting the students' hope and optimism. These were important features to be able to reframe their future in the challenging workplace. Reyes et al (2015) concluded that resilience was a process of applying personal protection and assisted the individual to modify approaches to challenging situations.

Arguably, Antonovsky's work still has contemporary applicability for midwifery practice in terms of the elements that were identified, namely: '*meaningfulness', 'manageability'* and *'comprehensibility*'. Antonovsky's (1987) theoretical work proposed a concept of coherence in terms of how an individual copes in times of stress. For example, to be able to cope during stressful midwifery practice experiences, '*meaningfulness'* is key in terms of the how the midwife perceives the work they are carrying out and the effect this might have on the women they are caring for. However, midwifery work needs to be '*manageable*', with sufficient resources, such as staff, adequate professional development and training to be able to carry out the work effectively. '*Comprehensibility'* is perhaps more difficult to achieve due to the unpredictable nature of midwifery practice and midwives not knowing what they will face on a day-to-day basis.

All of the above contributions provide differing foci to the resilience definition debate, but none provide sufficient clarity to be adopted for

student midwives. An understanding of the context that is required to develop resilience would perhaps assist a better understanding of the definition of the trait. Pooley and Cohen (2010) reviewed four research case studies, which were conducted in four different contexts, namely: adolescents in school, domestic violence in women, children in separated families and students adjusting to university, to further their understanding of the concept of resilience. These authors concluded that there was support in the literature of the research carried out to date in terms of the role that an individual's internal resources impact on their resilience; these include self-efficacy, coping and a sense of belonging. Pooley and Cohen (2010) also stressed the importance of social support to supporting resilience development. Pooley and Cohen (2010) found, in their review, that research was still needed about how resilience was affected by a range of contexts as individuals have different experiences and how they make use of the different variables. These authors also concluded that variables are not constant and change over time and that resilience is a '*multidimensional, multi-level construct'* (Pooley and Cohen, 2010:34).

As a result of their review, these authors proposed a new definition of resilience, namely:

> 'The potential to exhibit resourcefulness by using available internal and external recourses in response to different contextual and developmental challenges'.
>
> (Pooley and Cohen, 2010:34)

They argued that whilst these features were discussed in the literature they were not presented together as they have done. Whilst there is disagreement about whether resilience is a trait or an attribute that can be developed, Pooley and Cohen's definition appears, at first sight, to be helpful for healthcare settings as it implies that a range of

skills are required at different times, depending on the circumstances. Therefore, it is suggested that a framework of attributes and characteristics, to better understand how resilience develops or is inhibited in student midwives, is needed. Additionally, more clarity about how resilience can be promoted in midwifery clinical practice is required. The next section will explore how the literature discusses the promotion of resilience in individuals.

2.5 The promotion of resilience

Authors vary in their explanation of what are the '*right conditions'* to promote resilience. Rutter (2006) argued, in a review paper on resilience concepts, that there seemed to be strong evidence that there were differences between individuals in terms of their responses to the stressors they experience. Additionally, this author found in the literature support that stressful or adverse experiences could provide some protection to later episodes of stress. Rutter argued that there was a lack of good evidence determining what circumstances promote a reaction in the individual, but they are likely to be effective coping mechanisms, having self-efficacy and redefinition of the experience. This author offers a challenge to consider whether the term '*resilience'* is bringing new insights or simply describing some concepts that are already familiar.

Rutter (2006) proposed that research into the concepts of '*risk'* and '*resilience'* differ in their approach. Research into risk commences with the variables and then the outcomes, assuming that the effect of risk and factors that protect an individual will be the same for everyone, with the outcome dependent on the risk and any protective factors. In contrast resilience research, Rutter argued, recognised that individuals will respond differently to the same experience and by understanding this variation in responses will assist in understanding what interventions could be helpful. Risk research, however, is not

rejected, as resilience needs to be studied by considering both risk and protective factors.

Rutter (2006) also argued that resilience could not be measured as an observed trait as it is not a single trait and individuals may be resilient to some environment hazards but not others, for example, in controlled circumstance rather than avoiding the risk. Similarly, individuals may be resilient when some outcomes occur but not others and at certain times but not others. Another factor that Rutter highlighted was that protection can come about in both neutral and risky circumstances, even when there are no environmental hazards and what the individual does to deal with the stress of adversity with the affects occurring long after the experience.

Rutter encouraged a different direction for research to study the individual differences of comparable experiences rather than continuing to study resilience generally. The two aspects to consider are whether the variation in resilience results from an individual's risk exposure or that the outcomes measured differed.

Additionally, Rutter proposed that there may be environmental factors that affect an individual's ability to develop resilience (Rutter, 2006). Rutter (2006) considered that there were likely to be both physical and psychological changes in an individual as they acquire coping strategies. However, this author acknowledged that it is difficult to accurately measure the stressors that individuals are exposed to and how this may affect their resilience.

Fredrickson's (1998; 2004) theoretical pieces of work proposed the concept of '*broaden and build'* concerning positive emotions; this is of particular relevance to promoting resilience in student midwives. By an individual '*broadening*' their positive emotions, their personal

resources, such as attention, thinking, resilience, and well-being are also '*built*'. This theory discussed how equipped individuals are able to adapt in crises and how positive emotions are viewed as essential to function effectively. Using a multi-method approach, the '*broaden and build'* theory was tested with undergraduates in one American university (Tugade and Fredrickson, 2004). Tugade and Fredrickson used four tools to test the theory, namely: an ego-resiliency scale, a positivity and negativity schedule, an emotion report, a cognitive appraisal and cardiovascular readings. The aim of the study was to identify whether individuals relied on positive emotions to address negative experiences. Their analysis confirmed that positive emotions were significant and that there was a quicker cardiovascular recovery. Their participants were also able to find positive meaning from negative experiences. This theory has useful applicability to midwifery where reflection, specifically the ability to make sense of events, situations and actions, are key components of practice, resulting in the ability to develop professionally (NMC, 2015; 2018b).

Cohn et al (2009) found that harnessing positive emotions helped individuals to build up resources to deal with a wide range of life's challenges. Cohn et al's (2009) research study tested Fredrickson's '*broaden and build'* theory by recruiting 120 university students, across all programmes, via a newspaper advertisement, with a financial incentive offered to complete a diary for a month. Their results, from the 86 students that provided the daily responses required, suggested that an individual with positive emotions has greater resilience and life satisfaction. This sample was self-selected and the financial incentive may have had an influence on the participants' willingness to take part and on the responses made in their diaries.

Cohn et al (2009) found that positive emotions were key to individuals being more satisfied as they were able to build up resources to assist them in dealing with a range of life's challenges. Additionally, these authors found that life satisfaction correlated with positive emotions, which depended on growth in ego resilience. Involved in life satisfaction was the regulation of emotions, problem solving and the ability to change perspective. Their participants, with average and stable levels of positive emotions, demonstrated growth in their resources even when they experienced episodes of negative emotions. Cohn et al (2009) recognised the limitations of their study and suggested that their participants might have had enhanced impressions of themselves. Nevertheless, optimism and self-perception was felt to be a sound predictor of mental well-being and the ability to cope with challenges. These authors also suggested that Fredrickson's '*broaden and build*' theory responds to a range of everyday experiences, not simply unusual occurrences.

Although Cohn et al (2009) concluded that positive emotions, greater resilience and life satisfaction were intertwined, they recognised that long term follow up assessments would be important to determine their sustainability. Further complexity is added to the debate about the promotion of resilience where authors have focused on individuals being resilient at certain times but not at others (Davydov et al, 2010). The literature also describes how people may react differently at various times in their lives, implying that resilience is a dynamic process. These authors found that the definition of resilience and how it was measured varied. Davydov et al's model aimed to promote a more consistent approach to research. For example, Davydov et al (2010) conducted a critical literature review and used a multi-level, biopsychosocial model, which separated their findings into biological, psychological and social factors. These authors used this approach in an attempt to present the features of resilience as one concept, in

order to assess the effectiveness of interventions that would potentially increase resilience and mental health. Davydov et al (2010) defended their approach, as a meta-analysis of the papers was not feasible due to the different approaches adopted by researchers studying resilience. They argued that resilience cannot be measured precisely but only inferred from the risk an individual might have experienced and how they have adapted (Davydov et al, 2010:491). These authors suggested that remembering previous successes in coping with stressful episodes could contribute to well-being and promote resilience. Additionally, they argued that resilience cannot be considered purely from an individual perspective but should also take account of the group-level such as community and cultural influences. Davydov et al (2010) concluded that mental health research was being adversely affected by the differing methodologies and a lack of a single resilience definition.

What appears from the literature to be important for resilience is that a midwife has a positive approach to their work and integration into their profession, rather than just working for monetary benefit. Promoting resilience appears also to be linked with being both self-aware and self-reflective, which are traits of emotional intelligence. Therefore, an exploration of emotional intelligence will next be considered to ascertain if this concept offers a better understanding of the characteristics needed to be a resilient person.

2.6 Emotional intelligence and resilience

Midwifery is described as emotional work (Hunter, 2004). Midwifery textbooks state that student midwives should have the necessary skills to be able to cope with the range of emotional situations they face within midwifery practice (Mander, 2001) as well as providing emotional support to the women in their care (Kirkham, 2000).

A person who has emotional intelligence is said to be able to perceive, understand and control their emotions and monitor those of others, which are all key to midwifery practice.

Emotional intelligence is defined as:

> 'The capacity to reason about emotions and of emotions to enhance thinking…to reflectively regulate emotions so as to promote emotional and intellectual growth'.
>
> (Mayer et al, 2004:197)

Mayer et al's (2004) comprehensive literature review of emotional intelligence found that evidence was increasing that having emotional intelligence leads to a variety of outcomes, including better academic performance and the ability to communicate motivating information. They suggested that emotional intelligence was responsive to emotional information and that:

> 'emotions govern and often signal, motivated responses to situations'.
>
> (Mayer et al 2004:198)

Their review of early measures of emotional intelligence concluded that they were not reliable. Mayer et al presented a four-branch model of emotional intelligence and the instruments that they used to measure it. Their model is described as the ability of an individual to perceive emotion, use their emotion to facilitate thought, understand and manage their emotions. Mayer considered whether emotional intelligence was embedded within an individual's personality and that it progressively developed from being quite basic to becoming more sophisticated. They used the correlational patterns of emotional

intelligence scales in order to form one unitary factor that was different from a personality scale.

Mayer et al concluded that a highly emotionally intelligent individual can perceive emotions, use them in thought and manage them better. These authors also suggested that people who are emotionally intelligent are drawn to occupations that require social interaction. They defended their approach and the criticism about the reliability and measures of the emotional intelligence construct by arguing that their theory was embedded in the psychological literature. It is beyond the scope of this study to consider emotional intelligence specifically, but as student midwives have to deal with a range of complex emotional situations, academically and in practice, coping styles will be explored.

Grant and Kinman have written extensively about resilience and emotional intelligence in relation to social work students (Grant and Kinman, 2012; 2013; 2014) and have good applicability to midwifery. In 2011 these authors also argued that little was known about what competencies and support are reflected in people who describe themselves as resilient and how much this trait protects students (Kinman and Grant, 2011). They used six questionnaires, completed online, with 240 trainee social worker students to identify emotional intelligence, reflective ability, empathy, social competence and resilience, using Wagnild and Young's (1993) resilience scale. These authors also tested whether resilience predicted psychological distress. There were significant correlations between emotional and social competencies and resilience. They concluded that having emotional intelligence and social competence made the individual resilient to stress, protecting their well-being and protecting against professional burn-out. This rigorous study, using well-tested scales, has results that need to be considered for healthcare curricula. Of

concern was that this study found high levels of psychological distress amongst the students; Grant and Kinman concluded that interventions to enhance resilience were needed.

These authors provided an overview of the research that considered the benefits of emotional resilience for healthcare professionals; the introduction of the word '*emotional'* to resilience is not made clear (Grant and Kinman, 2014). They concluded that the attributes of emotional resilience are emotional literacy, reflective ability, appropriate empathy and social competence. They considered how resilience could be enhanced through self-awareness and self-knowledge, which might also affect retention. These authors recognised that there needs to be more evidence on the strategies that will be effective in promoting emotional resilience. They suggested how an organisation can promote emotional resilience for their employees, for example: ensuring that there are sufficient resources and clarification of their roles. These authors argued that emotional intelligence was a transferable quality from an individual's personal life. Although these authors focused on an individual's attributes, they stressed the role of organisations in promoting the well-being of its employees. Grant and Kinman (2012) proposed that an *'internal toolbox'* needed to be developed early on in an individual's career, suggesting that some direct action is required. The results of this study have good applicability to midwifery students, particularly as the social work profession faces similar challenges in the practice setting to those experienced by midwifery students.

A study of 130 diploma and degree-nursing students found that '*emotional intelligence was positively related to well-being, problem-focused coping and perceived nursing competence*' (Por, 2011:855). Their prospective correlational survey design used three methods: a self-report questionnaire, an audit of student performance and the

mapping of emotional intelligence teaching across curricula. Por's research found that when the nursing students felt in control they were able to adopt better coping strategies when they encountered stress. The significance of emotional intelligence, being able to assess one's own and others emotions, is critical within the healthcare environment in order to be able to demonstrate empathy as a compassionate caregiver. The author recognised the limitations of the study, namely, that it was conducted within one HEI and with one cohort of students, but felt there were similarities with other HEIs located in an inner city setting; a further deficit of the study was that it was not longitudinal.

The conclusion that can be drawn from the literature from related healthcare professions is that emotional intelligence and resilience are also required in midwifery students. In the next section, the literature, which discusses the factors and attributes that might affect the completion of a healthcare programme, are presented.

2.7 Factors and attributes affecting completion of the programme

A variety of terms are used in the literature when discussing the attributes a nursing student might need to successfully complete the undergraduate programme and prepare them to become a qualified practitioner. In a number of studies, including those considering registered nurses, it has been suggested that individuals who are empowered, in terms of their confidence in their abilities, are more resilient and that organisations need to change to promote resilience. Levett-Jones and Lathlean's (2009) mixed-methods, cross-national, multi-site, case study research with nursing students proposed the term '*belongingness'*. This large study involved 362 student nurses in the quantitative phase of the study and 18 in the qualitative phase of the study. Two of the sites were in Australia and one in the UK. Levett-Jones and Lathlean proposed that a student nurse can only achieve

competence if individual, contextual, and organisation factors are conducive. The pre-requisites to attaining competence were structured hierarchically to demonstrate the importance of promoting students to feel safe and secure in placement, have confidence in themselves and have a healthy self-concept. These authors concluded that in order for a student nurse to realise their goal of becoming a nurse, it is important to consider whether clinical placement settings proactively promote a student's sense of belonging. A student having a sense of belonging to the clinical practice setting appears essential for them to be able to better focus on gaining nursing competence without the distraction of feeling doubt in their situation and being able to feel committed to their chosen profession. This study presented some key recommendations to be applied within nursing education, to enhance the preparation of nursing students for practice so that they are better equipped to cope with their placements.

Monteverde (2014), in a quantitative pre and post-interventional study, found that nursing undergraduate students developed their resilience through their management of the stressors they encountered. Monteverde recognised that nursing students had to balance a range of competing objectives, namely: the demands of their studies, intellectual and organisational goals, the clinical placements and any demands in their personal life. The term '*novice*' is used to describe the characteristics of the student nurse when they first enter clinical practice. Additionally, there is the challenge of progressively being socialised into the culture they encounter. Monteverde (2014) stated that students observe clinical practice that does not always reflect evidence-based knowledge or sound clinical reasoning. For example, this author suggested that student nurses could witness clinical practice that registrants' explained as them having acted on '*gut feeling'* and '*intuition'* with patients, rather than on research evidence actions; this could be determined an abuse of power (Monteverde,

2014:2). This author, therefore, proposed that as well as developing psychological resilience, students also need to develop moral resilience in relation to ethical practice in order to deal with the complexity of clinical practice and the evidence that underpins it. It is acknowledged that this author's contribution is of interest to the discussion on resilience as it widens the challenges that students face in clinical practice.

McGillivray and Pidgeon's (2015) study aimed to examine the attributes of resilience in respect of mindfulness, psychological distress and sleep disturbance in university students. These authors used three scales: the Wagnild and Young (1993) resilience scale, the depression anxiety scale and the Freiburg Mindfulness scale, collecting data over one semester. Volunteer recruitment was gained through a university research participant online notice board and through direct approach in public university spaces. McGillivray and Pidgeon (2015) found that in the sample of 89 university students, those reporting high levels of resilience had fewer psychological issues and higher levels of mindfulness. The authors requested volunteers for the study, with the only requirement for them to be an enrolled student; course of study was not stated but more females than males took part. The study concluded that the promotion of protective resilience interventions should be adopted. McGillivray and Pidgeon (2015) recommended that the study should be replicated with a larger sample as they found variance in how resilience was reported by the participating students. The study with student midwives considers how resilience is viewed by another undergraduate cohort and uses Wagnild and Young's scale with this type of student for the first time.

It is interesting to consider the range of factors that might affect a student while they are on an undergraduate programme and the

attributes required. Resilience, however, may have more to do with the attributes an individual has at the commencement of the programme as well as difficulty socialising into the university environment. Tinto's (1975;1997) framework of attrition and its connection with integration will next be considered in terms of its application to midwifery programmes.

2.8 Tinto's model of attrition

Tinto (1975) developed a theoretical model of attrition, with its' roots in Durkheim's theory of suicide, following a multi-method, quantitative and qualitative study, which sampled first year students in one American college. The model aimed to illustrate a predicted theory of drop out behaviour from HEIs. The study considered how a student's pre-entry attributes were affected by their interaction with the academic and social systems within the environment of the university. Tinto found that collaborative learning helped to improve the academic-social divide that increases the individual's commitment to completing their programme. Additionally, Tinto suggested that an individual's personality affected attrition, whereby students who were impulsive and with less emotional commitment were more likely not to complete their courses.

Falcone (2011) described the three key criticisms of Tinto's original 1975 model. Firstly, it accounted for attrition from a particular institution and not whether the student had transferred to another. Secondly, the model focused on persistence at the end of the first year and beginning of the second year whereas persistence is necessary throughout the programme. Thirdly, the model was developed from a study of white, middle class students and does not reflect the wider student population. Additionally, Falcone (2011) argued that Tinto's model did not accurately describe the experiences of the wide range

of students who enter higher education, such as those from working class backgrounds or those with low incomes.

As a response to the criticism about its validity, Tinto modified the model, whilst retaining its' core elements (see appendix 13). Tinto (1993) switched focus to the classroom and proposed that the classroom was a common factor of all students' experiences, which could be the key to reducing attrition. Tinto also developed a definition of integration by suggesting it was a '*sense of belonging',* recognising the importance of the college environment and how the student engaged in the life of the institution. It could be argued that Tinto considered that academic and social integration occurred simultaneously. However, Tinto's later work suggested that social integration is key in the first year with academic integration occurring later (Tinto, 1997).

McCubbin (2003) argued that Tinto's model was not an adequate model of attrition as it could not be generalised beyond the traditional type of student. McCubbin questioned whether the lack of academic integration was an important predictor of attrition and called for the model to be verified. Tinto (1997), in response, argued that the model was not intended to be generalised to non-traditional students and the work had not looked at the individual characteristics of the students.

Draper's (2008) discussion paper, in a review of Tinto's models, argued that students must not just meet the academic standards of a midwifery programme but they should also demonstrate commitment to the midwifery profession as a whole. This has relevance to healthcare students, who have to negotiate two environments and the different cultures of academia and clinical practice. For the prospective midwifery student there can be a difference between what they believed midwifery to be and the reality of midwifery practice

when they are on the programme. Therefore, exploring how students cope is a way to gain a better understanding of the complex issue of retention, both on the programme and to the midwifery profession. This discussion highlighted the importance of midwifery students being determined to achieve their goal of becoming a qualified midwife, even if they face challenges.

2.9 Resilience and the effect of the clinical practice setting

Over 50% of the midwifery programme takes place in a range of NHS clinical settings under the support and guidance of a number of registered midwife mentors. Anecdotally, midwifery students will often describe at the start of the programme that the practice placements will be the highlight of the programme. Students need to socialise into the midwifery profession while in the clinical setting. Curtis et al's (2012) grounded theory study explored 19 student nurses' experiences of socialisation into clinical practice with a particular focus on compassion. This particularly affects students who find socialisation into the profession difficult or who are not committed to the programme (Curtis et al, 2012). They found that the students dissatisfied with the quality of care they provided felt they were stressed as a result; these findings were compared and found to reflect Care Quality Commission data. Curtis et al (2012) suggested that this dissonance between expectations and the reality of practice was problematic.

Curtis et al (2012) did not specifically use the term '*resilience*' but it could be argued that this is what the students were demonstrating to cope with the placement settings. In this paper it was also reported that student nurses' caring behaviour declined as they neared the end of the programme; unfortunately, the paper only discusses selected findings. Additionally, Curtis et al's (2012) research did not explore what, if anything was being done to address the negative culture

within the clinical practice setting that the students were experiencing. Nevertheless, other research concurs with Curtis et al's findings, namely that across the disciplines they studied, students' inability to adapt to the competing demands played a significant role in student attrition (McIntosh et al, 2013; Fowler and Norris, 2009).

It is suggested that students are unprepared for the emotional and stressful demands of midwifery and that successful socialisation into the profession is important (Green and Baird, 2009). These authors cited Tinto's (1997) work about the significance of integration to students remaining on an educational programme. Green and Baird (2009) argued that there is limited evidence that details the experiences of students that lead to both attrition and retention. Green and Baird's exploratory comparable design reviewed attrition from three-year and 78-week midwifery programmes through sending 36 questionnaires to students who had left the programme and through 16 current students who attended focus groups. Green and Baird concluded that there was rarely one reason for leaving a midwifery programme and attrition is often as a result of what was happening in the practical and theoretical settings. They reported that midwifery attracted very motivated students and it was important to nurture this throughout their programme.

It is disappointing that Green and Baird (2009) found that the student midwife on the three-year programme felt overwhelmed and unsupported, feelings exacerbated when their values were challenged in clinical practice despite being very motivated to becoming a midwife. Green and Baird (2009:87) proposed that collaborative approaches between academics and clinicians are needed in order to offer '*consistent and organised support'* and mentorship. Additionally, students needed to be supported by midwifery academics to adapt to the culture of midwifery whilst nurturing their motivation for them to

be able to cope when they are feeling less positive about the programme and midwifery. The academics being clinically credible was found to be important in maintaining motivation in the students. This is an interesting observation where the trend anecdotally appears to be individuals moving into education earlier in their midwifery careers and not retaining strong links with midwifery practice. The effect of the midwifery lecturer being remote from clinical practice could widen the theory/practice gap, which could exacerbate students' negative perceptions.

A criticism of Green and Baird's study is that although the participants were matched demographically, both three-year programme and shortened midwifery programme students were compared, which could be argued are not comparable and comparing cohorts on the same programme may have been more appropriate. There was no overriding factor that affected attrition in Green and Baird's study but more likely a combination of personal, theoretical and clinical reasons. The participants' drive to remain on the programme came from support systems outside the programme and resilience to see the long-term benefits of gaining a midwifery qualification. Green and Baird concluded that further work into students' perceptions of the emotional demands of midwifery remained unclear in this study.

Roxburgh (2014) described how it was the students' own resilience reserves that kept them on the programme when they had negative experiences in the clinical environment. This paper reported phase two of a study that examined students' perceptions of both '*hub and spoke'* and '*rotational placement'* models. Phase one of the study had examined the students', mentors' and managers' perceptions of a '*hub and spoke'* model in year one of the undergraduate nursing programme. Roxburgh's (2014) focus group interviews with 10 undergraduate student nurses found that they were very anxious prior

to going to a new placement and were particularly concerned about whether they would '*fit in'* and be liked by their mentor. The relationships with mentors had to be re-learned each time they went to a new area. The limitations of the study were in respect of the small numbers of participants. Nevertheless, the suggestion that resilience can be developed through a structured and supportive first year in practice is of interest. This questions the rationale for moving a student midwife too frequently in the programme and whether this has any impact on their resilience.

The Royal College of Midwives' (RCM) (2011) survey of 763 student midwives reported that 10.2% of the students that left the programme had done so as a result of bullying. The content analysis highlighted factors which contributed positively to student midwives' experiences, including midwives that took an interest in them, passionate midwives and supportive mentors. However, there were some negative experiences, including that some colleagues were rude, the difficult culture and environment of midwifery, difficult or judgmental midwives and lack of team spirit. Some students reported that the induction to the placement and their mentorship was poor. The reality of practice was described as being both disappointing and concerning (RCM, 2011). These findings are of concern as it could lead to students becoming disillusioned and concerned that midwifery was not the right career choice for them when practice did not live up to their expectations. The majority of the respondents were in their first and second year of the programme but there was no explanation as to why third years were not well represented. In contrast, however, the report found that the overwhelming majority of students did report that they were meeting the competence expected for their stage of the programme. It is not clear how the report equated that achieving competence meant that the participants were being socialised or felt

confident in supporting individualised woman-centred care, both factors not reflected in Hunter's (2004) study.

Hunter (2004) reported that the reason for emotional discomfort amongst midwives was unexpected. This author recognised that the literature cited the midwife/woman relationship as being the key source of emotional reactions. This qualitative study, using an ethnographic approach, collected data in three phases, using focus groups, observations and interviews. In phase one the study participants were 27 student midwives that self-selected, and a convenience sample from both 18-month and three-year pre-registration programmes. Phase two involved an opportunistic sample of 11 qualified midwives of different grades and from a range of locations. Phase three was a purposive sample working in one Trust across a number of clinical grades, years of experience and working in a range of locations.

The rationale for the different methods and phases in the research study was not given. The author stated that there were limitations to the study, in terms of generalisation, due to the location and sample; there were fewer in the sample, and the experiences of the senior midwives in the hospital setting were not captured. Nevertheless, Hunter found that the key source was a dissonance in ideologies of midwifery practice, which caused adverse emotional reactions in midwives. A student midwife who enters the programme is likely to have a number of preconceived ideas about what midwifery is going to be like. The decision to become a midwife may be based on a strong self-belief of how midwifery should be practised. Therefore, if, as Hunter suggests, the reality of midwifery practice is quite different from what it was thought to be and challenges a student's value base, then unease about the profession they have chosen is possible.

Within midwifery undergraduate programmes two cultures have to be negotiated, namely education and the clinical practice environment. Socialisation into the midwifery profession plays a key role in the student experience and Tinto's (1997) work can be applied here in terms of the importance of successful integration.

Johnson et al's (2012) theoretical discussion paper suggested that professional identity is a key attribute to acquire if the student is to successfully become a nurse. These authors recognised that the link between professional identity and retention has not been evaluated. However, low self-esteem certainly seems to affect retention. The identity of a nurse and a midwife needs to be shaped during their preparation and programme, and to continue to be developed throughout their career.

Other authors have highlighted the importance of nurturing resilience as a protective mechanism against challenging working environments. For example, McAllister and McKinnon's (2009) review of the teaching and learning of resilience in the health disciplines concluded that workplace affected resilience. This is particularly important in healthcare environments where there are challenging encounters. McAllister and McKinnon (2009) defined resilience as:

> 'the ability to overcome adversity and includes how one learns to grow stronger from the experience…'
>
> (p.372)

And also as:

> 'an internal locus of control, pre-social behaviour, empathy and the ability to organise daily responsibilities… in addition, resilient individuals appear to be more adaptable to change…'.
>
> (p. 373)

McAllister and McKinnon's (2009) critical review of the resilience literature in the health professions widens the definition of resilience to include not just the individual, but also ways of working, which need to be facilitated by the culture of the organisation. McAllister and McKinnon argued that the concept has, to date, been ignored in higher education where healthcare professionals receive preparation for the workplace. These authors stressed that not only do individuals need to develop social connections but they also need to have experienced effective role modelling. This could give healthcare educators the impetus to embed the development of resilience skills through ensuring that students have contact with positive role models within their healthcare programmes.

McAllister and McKinnon's (2009) definition, which described resilience as growing stronger from the experience, has resonance for midwifery practice. For example, these authors' definition clearly indicates that some action is required to develop resilience but seems to place the responsibility on the individual. Unfortunately, this definition does not discuss the importance of the employer acknowledging their role in ensuring the practice environment promotes resilience. If resilience is built through education, training and modifications in workplace culture, then some key changes to policies and practices will be required.

If a resilient person is one who can recover from difficult situations, it could be suggested that a person needs to be made aware of the effect certain situations have on them. McDonald et al (2012) adopted a case study approach, using an educational work-based intervention with nurses and midwives to develop and strengthen their resilience. The study held workshops for staff from a clinical area that had a history of high profile adverse patient outcomes and staff bullying. It

was concluded that resilience played a key role in maintaining participants' sense of well-being, even where there were challenging situations. McDonald et al recommended that organisations need to use approaches to support resilience, in addition to what the individual does. Arguably, the generalisability of the study could be limited, as the intervention was potentially being implemented to address wider institutional issues; stress levels amongst staff being higher than normal. McDonald et al (2012) recommended, however, that the effect of workplace culture warrants further study.

Pryjmachuk et al (2009) used a cross-sectional, retrospective cohort survey to determine which variables predicted stress in pre-registration midwifery students. They found that out of 1,259 students, over 40% of the participants described themselves as stressed. However, Pryjmachuk et al (2009) stated that this percentage was comparable to other undergraduate students on different programmes or to rates found amongst qualified healthcare professionals. They concluded, however, that the factors associated with stress should still be considered when developing the curriculum and support strategies put in place for both the theoretical and clinical aspects of the programme.

Pryjmachuk et al (2009) also found that mature students, those over 25 years of age, were more likely to complete their programme, citing increased motivation and resilience as possible reasons. Mature students also reported that it took time to adjust to the requirements of the course and to develop coping strategies. Mature students in their third year reported that following a challenging start, they had developed the strategies required to better cope with the demands of the programme (Carolan-Olah et al, 2014; Carolan and Krugar, 2011). However, the participants considered it was primarily their own

personal strength and determination that had helped them to overcome the challenges they met on the programme.

It can be concluded from the literature, therefore, that it is important that midwifery lecturers and clinical midwifery mentors are aware of what is happening to midwifery students while they are in the practice setting, so that timely support and guidance can be offered as required. It is crucial that the effect of the clinical practice setting on student midwives, in the current NHS environment, is considered when trying to determine their experiences. Personal resilience has been suggested to be key in enabling midwives to work more successfully in practice as they maintain job satisfaction, as well as their own health and wellbeing (McAllister and McKinnon, 2009). Research has suggested that it is specifically the personal resilience trait that is required to be a midwife (Hunter and Warren, 2013). These authors were interested in the issue that some individuals complete the programme but only practise as registered midwives for a short period of time before leaving the profession completely. Hunter and Warren's study explored the reasons for staying in midwifery and what supported this. These authors used the phrase '*critical moment'* to indicate when midwives were at their most vulnerable and particularly needed resilience when they were caring for women with challenging circumstances and when a midwife was first qualified (Hunter and Warren, 2013:2). Nevertheless, these authors warn against simply introducing programmes that target the individual's development of resilience without addressing the context.

Crombie et al's (2013) ethnographic case study research conducted focus groups with 28 participants and a further 15 one-to-one interviews with second year nursing students, those about to graduate and those who had graduated the year before. The factors that influenced the attrition and completion rates in year two nursing

students were how they identified themselves as students, actions taken to foster resilience, their focus on the final goal of becoming nurses and the support they received in the placement area (Crombie et al, 2013). Students also described how they needed to '*fit in*' to the practice environment and experienced difficulties if they were not seen as being the '*ideal type*' to be a nurse; as defined by the qualified nurses (Crombie et al, 2013:1284). Students cited that they were unprepared for the attitudes of some of the staff in practice. This suggests how significant the mentors' influences are on student experience in the clinical environment. This is of concern, since what this implies is that the mentors could be informally assessing the students' suitability to progress, which may lead to a student being '*labelled*' and this '*label*' could move with them around the practice areas irrespective of where or with whom they were working with, or whether it was justified.

The students in Crombie et al's study were found to foster greater resilience when the academic and clinical environment better supported them. Support had been key to remaining on the programme, with the support being gained from a range of sources, namely: family, friends, peers and academic staff, with no one particular area of support superior to another. This aligns to some degree with Tinto's (1975) integrative model where both academic and social integration were key to success. Tinto's model is suggested as providing a useful framework to support an understanding of resilience (Crombie et al, 2013).

Crombie et al (2013) argued that offering a range of supportive measures to students in both the academic and clinical environments encouraged greater levels of resilience. The importance of students being debriefed so they can reflect on their practice is key to aiding their understanding of midwifery practice. Wagnild and Young (1993),

whose updated 2015 resilience scale has been used in this study[2], suggested that by being resilient an individual is able to overcome adversity and adapt to their environment. This is particularly apt to the midwifery student who, like other healthcare professional students, has to navigate a challenging programme between academic and clinical environments.

It has been found that students have a growing commitment and interest in the profession as they progress through the midwifery programme (Sidebotham et al, 2015). In Sidebotham et al's descriptive, exploratory study, the authors wanted to explore the experiences of second and third year midwifery students and whether there were any factors that could predict student satisfaction and progression on the programme. Sidebotham et al's findings regarding resourcefulness could be applied to resilience in respect of continuing on the programme, which concurred with Green and Baird's (2009) findings. Additionally, the students in Sidebotham et al's (2015) study, who had developed a strong sense of self, in terms of '*connectedness*', were more satisfied on the programme. Sidebotham et al (2015) suggested that there has been a renewed interest in the literature of the need for healthcare students to have a sense of vocation to be effective. Therefore, the traits of feeling '*connected*' to the programme and midwifery, and of viewing the profession not just as a job but a vocation, resonates with what would facilitate the student in becoming a midwife.

An on-going review of the published resilience research during the period of this study was undertaken. There remains no published literature to date pertaining to student midwives and resilience, which has provided continued justification for this research. This chapter will

[2] Personal communication with Gail Wagnild.

present a critique of the literature reviewed and the themes that emerged.

2.10 Critique of the literature reviewed November 2015 to November 2018

The original literature review, which informed the design of the study, was undertaken in 2015. Since then, further literature of relevance has been published or found. Whilst this did not impact on the original design, it could be taken into account in discussing the findings of this research study. Eight papers of significance have been identified as a result. These can be placed under two themes; six considered the concept of resilience and two, retention and attrition.

2.11 The concept of resilience

Crowther et al's (2016) discussion paper explored the concepts of sustainability and resilience to determine how useful the terms were in midwifery practice. The paper compared, contrasted and explored two primary research studies, one from the UK and one from New Zealand. The authors found that the concepts of sustainability and resilience had four overlapping themes which were key to '*sustaining healthy resilient practice'* namely: self-determination, ability of self-care, the ability to form relationships professionally and with women and passions/joy for midwifery (Crowther et al, 2016:44).

Crowther et al (2016) argued that resilience was being seen as the concept to resolve poor current midwifery practice environments and needed to be reconsidered. They argued that learning resilient behaviours did not equate with the midwife's strategies being beneficial or sustainable for any period of time. Crowther et al (2016) felt that what remained unclear was the effect of different models of care on sustainable long term practice and promoted healthy resilient behaviours. These authors appear to challenge the popularity of

promoting resilience as a concept that requires midwives to '*toughen up*' and accept the poor practices prevalent in the work.

Cope et al (2016:121) concurred with Crowther et al (2016) that resilience is being seen as a trait that should be learnt to cope with due to a '*chaotic*' healthcare system, but the term is not defined. Cope et al (2016:117) used qualitative portraiture methodology; defined as the researcher, the '*portraiture*', who listens to the stories of the participants with a focus on strength rather than deficiency. The study explored the relationship between resilience and new managerialism in contemporary nursing. There were only nine participants in this study but the findings reflect other researchers' work. Therefore, it could be viewed as disappointing that the practice setting is described as challenging and as having a potentially adverse effect on students.

Thomas and Revell (2016) argued, in their systematic review and meta-analysis of resilience in nursing students, that in order to learn about the realities of clinical practice, emotional resilience needed to be developed. They only found nine papers, all but one defined resilience from a psychological discipline; one study had developed a specific definition for nursing students. Thomas and Revell suggested that the research into resilience to date was in its early stages and that although a definition for nursing has been developed it has not been tested. Nevertheless, these authors did state there was sufficient research to ascertain ways in which to promote resilience, although they were not specific about the evidence for this.

McGowan and Murray (2016) undertook a literature review, searching for quantitative and qualitative research on resilience in nursing and midwifery students that had occurred over a 35 year period, 1980 to 2015. Although these authors used five databases for their review of resilience and hardiness, they only found eight quantitative papers of

relevance, confirming that research relating to nursing and midwifery resilience was sparse; no studies related to student midwives. McGowan and Murray found that there was evidence, albeit weak, that resilience and hardiness are associated with improved academic performance and reducing burn-out. They suggested that the eight papers were different in design and proposed that the quality of the methodology was poor, making comparisons not feasible. For example, the studies that used pre- and post-tests did not have control groups and sample size calculations were missing.

McGowan and Murray argued that there was a need for theoretical underpinning to the concept of resilience and healthcare professional students. They also proposed that more research was needed to support the use of any training strategies that claim to develop resilience. McGowan and Murray's findings provided further support to this study, particularly to advance resilience understanding in student midwives.

2.12 Retention and attrition

The RCM (2016) conducted a membership survey to establish why midwives leave the profession; a follow up from the original one that had been conducted 15 years previously. The RCM received 2,719 responses to the survey. It was not clear what the response rate or size of the sample was but 30.8% responses were from midwives who had left the profession in the previous two years and 69.2% of the responders intended to leave the profession in the next two years. The top five reasons for leaving were dissatisfaction with staffing levels, the quality of care they could give, workload, working conditions and the model of care they were working in. The RCM concluded that addressing staffing levels in midwifery practice would reduce the number of midwives leaving and encourage those who had left to return. The RCM is a reference source to prospective students and,

therefore, the findings of this survey could impact on midwifery as choice of profession. This survey inevitably has significance to student midwives who will also experience what the midwives reported; this may impact whether they remain on the programme as a result.

The HEE RePAIR (Reducing Pre-registration Attrition and Improving Retention) project aimed to better understand what could be done to reduce attrition in healthcare undergraduates in England (Lovegrove, 2018). The project also wanted to standardise a definition of attrition and review best practice for reducing attrition in order to promote a national approach to the issue. This project was large in that it involved 16 case study sites, 18 HEIs and 23 healthcare providers. The breakdown of participants were as follows: 155 students, 25 newly qualified healthcare practitioners, 67 academics, 63 clinical educators and seven national policy advisors. An online survey was completed as well as 46 meetings, held in 33 different occasions, to capture the stakeholders' views and opinions on attrition.

Lovegrove (2018) found that there was not a nationally agreed way of determining what attrition was, which means that studies are difficult to compare. Although the recommendations of the RePAIR project did not discuss resilience per se, the importance of support for the healthcare student was discussed, with examples of good practice, which included buddying schemes and a national scheme of support in the clinical area. The recommendations of the RePAIR project have some clear actions for HEIs and placement partners, including the role of the student being supernumerary and a uniformed approach to clinical assessment. Some of the recommendations of the RePAIR project are more difficult to achieve, such as ensuring that prospective healthcare students avoid a wrong career choice through information and advice about the profession. Whilst information is key to all prospective students, the reality of clinical practice is difficult to

prepare a student for. It could be argued that more opportunities to experience clinical practice prior to commencing the programme should be on offer.

2.13 Summary

In summary, these new papers demonstrate that issues in respect of midwifery attrition continue and the role of resilience for student midwives remains unclear. The continued dearth of resilience research in respect of student midwives provides further confirmation of the need for this study to be conducted. The link between resilience and attrition continues to be discussed alongside factors that affect the trait being maintained within the clinical setting.

2.14 Conclusion

Resilience as a concept is prevalent across a range of literature studying healthcare professionals. There appear to be inconsistencies between studies that have researched resilience in healthcare professionals, in terms of how they define and measure the concept, so generalisation is difficult. A more consistent approach to researching resilience in healthcare professionals should be adopted.

The vastness of the resilience research meant that this review required clear inclusion and exclusion criteria. Only literature pertaining to resilience in healthcare students was reviewed, which meant that it was focused and had the potential to be generalisable to student midwives.

Although the link between being resilient and leaving healthcare programmes is not firmly established in the literature, the development of resilience does potentially support the student to be able to better cope with any stressors that may occur both inside and outside the midwifery programme. It has been found that, regardless

of healthcare discipline, the student's inability to adapt to competing demands plays a significant role in attrition (Fowler and Norris, 2009; McIntosh et al, 2013).

The literature reviewed concluded that the development of resilience potentially enables the student to cope better with the stressors they are experiencing both inside and outside of the midwifery programme. Resilience is also considered a transferable skill between an individual's personal and professional life (Grant and Kinman, 2014). Thus, the concept of resilience has been suggested to embrace the knowledge, the personal qualities and the skills that are required to be successful. Tinto's (1975; 1993) discussion about pre-entry attributes has resonance for midwifery. Arguably, if a student integrates into both the university and the practice setting, with commitment to the profession, this enhances the potential foundation for remaining on the programme. What is not clear is whether it is resilience or some other trait that enables students to continue on the midwifery programme.

Resilience seems to be an attribute that is aspired to, but the literature reviewed does not provide insights into its significance to student midwives. To date there remains a lack of research in respect of resilience and student midwives. It was considered that student midwives may see resilience differently, or alternatively there could be some similarities with other healthcare professionals. The term resilience is used in a wide range of contexts with a variety of meanings.

Grant and Kinman's (2012; 2013; 2014) research focused on social work, which aligns well with midwifery. Midwifery students need to personally develop so they can cope psychologically and socially with midwifery practice, particularly with the institutional demands of an

organisation such as the NHS. Further evidence is therefore needed to establish whether resilience plays a significant role in the preparation of student midwives for the midwifery profession.

The critical review of the literature has informed and shaped the development of my research study. Hunter and Warren (2013) recommended that longitudinal research be conducted with students and newly qualified midwives to investigate how resilience develops, or not, over time. Hunter and Warren's recommendation and the gap in knowledge in relation to student midwives provided the rationale for this study. By undertaking the study over the first 18 months of an undergraduate midwifery programme, it has provided justification for this study to be longitudinal in nature, reviewing the experiences of the student midwives over a period of time. The methods used to collect the data in this study were considered to be the most effective for rich data to be gathered about resilience within the student midwife cohort over a discrete time period.

A decision was taken for the students to come up with their own definition and understanding of resilience and then compare this with the definitions provided in the literature.

Chapter 3.0 Methodology, research design and methods

3.1 Introduction

The aim of this research was to identify whether resilience developed or not during the first half of a three-year midwifery undergraduate programme. The longitudinal nature of the study enabled data to be collected over a period of time, namely 18 months. This study used a single case study design that explored the views of student midwives regarding the concept of resilience.

As revealed in the literature review, there is a paucity of data that explores how midwifery students deal with the reality of midwifery practice. This study addresses this gap in the knowledge base by exploring the experience of being a contemporary student midwife. This chapter presents the epistemological considerations and the rationale for adopting a case study approach. The research design is discussed, exploring the different methods that were used to gather the data. Ethical considerations are presented, including the issues related to undertaking this study as an insider-researcher. The handling and checking of the data are detailed, including the methods of analysis used.

3.2 Epistemology considerations

The term epistemology concerns itself with what is counted as knowledge and what it is possible to know (Braun and Clarke, 2013). An epistemological approach is interpretative and to build theory it involves:

> 'understanding meanings/contexts and processes as perceived from different perspectives, trying to understand individual and shared social meaning.'
>
> (Crowe et al, 2011:10)

Constructivists argue that knowledge is not waiting to be discovered but rather is constructed through various discourses. Quantitative and qualitative research each adopts its own focus that results in the production of different knowledge and claims. Yazan (2015) argued that qualitative researchers are most interested in the way people make sense of their experiences in the world. Central to qualitative research is its search for meaning and Braun and Clarke (2013) considered that although qualitative research is complex, patterns in the data can still emerge. Qualitative methodology was predominantly used in this study as it was felt to be an appropriate approach to explore meaning and complexity in the experiences of student midwives.

> 'A qualitative approach is one in which the inquirer often makes knowledge claims based primarily on constructivist perspectives (i.e., the multiple meanings of individual experiences, meanings socially and historically constructed with an intent of developing a theory or pattern)'.
>
> (Creswell, 2003:18)

This research reflects constructivism as it was recognised that the knowledge in the study is socially constructed from the reality of the student midwives' own internal view of midwifery practice as they experience it. Constructivism emphasises that knowledge can emerge through the individual's interaction with the environment in the course of the experience. A student understanding is formed through reflecting on their personal experiences and then relating the new knowledge to what they already possess. When applying this to teaching approaches, constructivism emphasises the active role of the student in the educational process and their ability to construct new knowledge through previous experience and previously acquired knowledge. This position aligns well with my own teaching and

learning philosophy of the need for the student midwife to be active and an essential partner. This is so that they can develop the skills required to learn both independently and responsively beyond the curriculum to promote learning throughout their midwifery career. Furthermore, qualitative researchers argue that they are not seeking the absolute truth but want the plausible findings grounded in the data (Plack, 2005).

3.3 Using a case study approach

Hartley (2004) suggested that case study research is particularly suited to research questions that require a detailed understanding of social or organisational processes; it is a research strategy rather than simply a method. Hartley (2004:323) stated that case study research involves '*detailed investigation, often with data collection over time*', which was reflected in this study. The key to a case study approach is the study of phenomena that is occurring within a particular context. The result can be that the context and processes of a study are analysed to generate or replicate theory.

Several authors have discussed the case study approach in depth, namely: Yin (2002; 2009; 2018); Merriam (1998; 2007; 2016); Stake (1995; 2006; 2014) and Bassey (2004). Each author has their own perspective on case study research, how they define it and what they recommend to a researcher in terms of how they should conduct their research; each evolving their own ideas over time. Yin (2018) provided detailed discussion about how it could be ensured that the case study has a structured design with guidelines and is rigorous. In contrast, in 2014 Stake proposed a more flexible approach to the case study design, allowing changes even when the research is in progress. Alternatively, Merriam (2016) supported a wider view of what a case study is, as long as the researcher can articulate its boundaries.

In 1995 Stake argued that the case study approach should be informed through constructivist and existentialist epistemologies. This author suggested that most qualitative researchers consider that knowledge is *'constructed'* rather than *'discovered'* (Stake, 1995:99). It was proposed that the researcher is an *'interpreter'* and a *'gatherer of interpretations'* who will present the constructed view of reality. Merriam (2016) concurred that reality is not objective, but individuals who construct it interact with their social worlds.

The case study has a long tradition in healthcare practice and education research. Crowe et al (2011) argued that the case study approach is adopted where there is a need to explore the *'event or phenomenon in depth and in its natural context… referred to as a "naturalistic" design'* (Crowe et al, 2011:8).

Case study research will produce narrative that explores real life in detail (Flyvbjerg, 2006). Case studies are proposed to focus on:

> '…a particular phenomenon with a view to providing an in-depth account of events, relationships, experiences or processes occurring in that particular instance.'
>
> (Denscombe, 2010:52)

Stake (2006) proposed three types of case study, namely: intrinsic, instrumental and collective. The instrumental case study is where the case itself is of the primary interest, with the uniqueness of the individual or situation being the impetus for the study. In contrast, the collective approach involves studying multiple case studies at the same time. An instrumental case study was chosen as being the most relevant for this study as it provided insight into the issue of student midwives and resilience, with the findings being able to be applied beyond the case itself (Silverman, 2013). The case was considered

typical and potentially representative of any midwifery programme delivered in the UK and the data it generated were rich and detailed.

This case study was defined by what was common and what was particular about the study's group of student midwives (Stake, 2006). Flyvbjerg (2006:231) discussed the concept of the *'critical case'*, which would consider either the *'most likely'* or *'least likely'* case. This study involved the *'most likely'* case, which explored the real life *'experience'* of being a student midwife and the role resilience may or may not play (Braun and Clarke, 2013). This study examined patterns of behaviour in student midwives that may or may not have demonstrated growth in their resilience.

Yin (2018) proposed four benchmarks to ensure quality in case study research, namely: construct validity, internal validity, external validity and reliability. The benchmarks should be considered in all stages of the research, including the design phase, during data collection, analysis and the writing up. However, Yin's view of a case study as positivist in nature does not align with this case study. Nevertheless, in choosing to align this longitudinal research study to a case study approach, rigour in the approach throughout all its stages will be demonstrated.

Bassey (2004) proposed that an educational case study should be reconsidered and argued that, as an approach, it lacked clarity of purpose. Bassey considered that as a case study is located in educational research, it provides the opportunity in certain types of cases to increase the understanding and knowledge of the discipline by theory seeking and testing. By exploring the features of the case study, Bassey (2004) also considered that with an accurate audit trail, other researchers could validate or challenge the findings and present different arguments should they wish.

3.4 The research design

The study comprised an initial and a main study (see figure 1). The main study was longitudinal, with one cohort of participants over the first 18 months of an undergraduate midwifery programme. The rationale for adopting different methods in this study was to maximise the richness of the data collection and create more of a holistic picture. Each method was chosen for its ability to investigate appropriately the concepts being studied. It is recognised that the adoption of different types of data collection tools has similarities to a mixed method study. However, the intention was not to merge paradigms that, according to Turnbull and Lathlean (2015), are an essential feature of mixed methods research. Each method in this study was specifically selected for its ability to answer the individual research questions and to enhance the range of data on the different aspects of resilience in student midwives.

Five methods of data collection were selected, namely: biographical data, assessment scores, the administration of Wagnild and Young's (2015) True Resilience Scale©, focus groups and one-to-one interviews. Immediately prior to the administration of the scale all the participants completed a form detailing their biographical data. The participants' assessments scores were gained from their personal files at the end of the 18-month period of the study. It was acknowledged that using several methods would produce a large amount of data but nevertheless it was felt to be important to enhance the comprehensiveness of the findings about resilience.

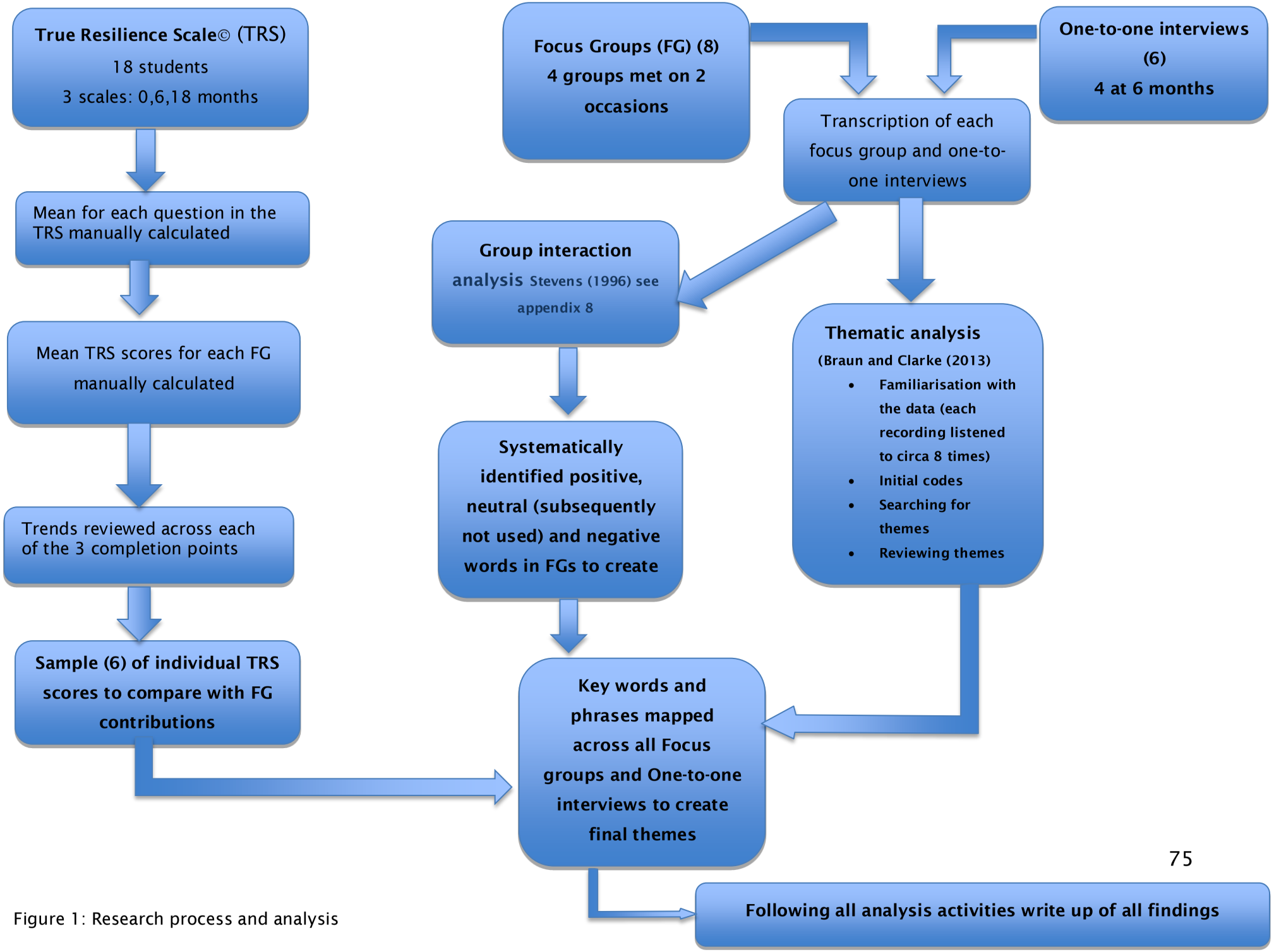

Figure 1: Research process and analysis

No method was prioritised as each collection tool was used to enrich the understanding of the topic in its totality and to address the different aspect of the investigation. The True Resilience Scale© had not been employed previously with student midwives and, therefore, as well as its use in providing scores for the participants, there was an interest in exploring its appropriateness and applicability for a cohort of student midwives. Focus groups were selected to enable the participants to discuss and work as a group in a semi-structured way to present their views. Following preliminary analysis of the focus groups, a number of students who had particularly raised points of interest that warranted expansion were invited to attend a one-to-one interview to explore their contributions in more detail.

Baxter and Jack (2008:554) argued that in a case study the data collected are pieces of a '*puzzle'.* These authors use the term '*braiding'* to describe how the greater understanding is achieved. In this study the individual methods were initially analysed separately and then compared and contrasted with the research questions to gain a holistic understanding of what resilience meant for student midwives. The data were not integrated as each method had different aims and presented its own results.

3.4.1 The use of the quantitative tool in this study - The True Resilience Scale©

The True Resilience Scale© was used to gather data in relation to the development of resilience in the participants over the study period. Permission was given for its use, without payment, by one of the authors; this was very helpful as the scale is not normally in the public domain unless purchased. The 2015 version of the Wagnild and Young's (1993) True Resilience Scale© was used (see appendix 4).

Wagnild (2009) found that the internal consistency of the resilience tool was consistently high in 11 of the 12 studies that were reviewed, i.e. Cronbach's alpha co-efficient ranges from 0.85-0.94, with the lowest coefficient being 0.75. Wagnild (2009) suggested that the tool was not only internally consistently reliable but also robust, meaning that the scale has been able to be used in multiple studies, across all ages and ethnic groups, and has also been translated and adapted for use in a number of different countries and used with a wide variety of age groups, from adolescents to adults and contexts (Damásio et al, 2011).

The True Resilience Scale© tool uses a 7-point scale from 1 (disagree) to 7 (agree). All items are positively worded, which Cluett and Bluff (2006) cited as a commonly used approach to measure attitudes. The scores range from 25-175 with the higher scores indicating a higher degree of resilience. The participants were advised about how to complete the scale, particularly that only one answer for each statement was required and that there were no wrong or right answers. Each True Resilience Scale© has 25 questions to complete (see appendix 4). The resilience scores were obtained by adding up the scores of each item. The possible lowest score for any item was 1 and the highest score was 6; therefore, the lowest possible total score for the 25-item True Resilience Scale© could be 25 and the highest 150.

In this study the scales were not anonymised in order to link each completion of the scale back to each individual student and feedback their results at the end of the study. The rationale for the participants not being given the results of their resilience scores until the completion of the study was to reduce any potential change in the students' responses by knowing their on-going results.

I remained in the room while the participants completed the scale by hand. The participants were not hurried, being given time to think about their responses.

3.4.2 The use of focus groups in this study

The focus group method in this study was selected to facilitate the participants to discuss complex issues by working together to consider the response, gauging to what extent their views were shared (Denscombe, 2010). I wanted the participants to be able to share their ideas about resilience through a discussion with other student midwives to enable them to hear a range of perspectives; therefore, conducting focus groups was the best method to meet this aim.

Focus groups can facilitate *'naturalistic talk',* which will reflect everyday life that is achieved if the participants work together well (Green, 2014:134). I was interested in learning about what the participants thought about the concept of resilience in midwifery practice and how they had come about these understandings. It is important to ensure that the participants are at ease and feel that their views are respected (Kreugar and Casey, 2015). However, it is recognised that this will require good facilitation in order to generate a discussion that can be *'heard, transcribed'* and *'analysed'* (Green, 2014:136).

Cyr (2016) argued that focus group dynamics can induce social pressures so that the final results are a group response rather than that of an individual, and they suggested that participants might exaggerate, minimise, or even withhold experiences. Barabas (2004) highlighted how deliberation can change individuals' responses as they work through multiple and potentially conflicting views on a topic before arriving at a final constructed opinion. Therefore in applying these considerations to this study it was key to try not to focus purely

on the consensus or disagreement to the questions but rather the process towards the final decision.

Focus groups are often used in conjunction with other methods such as interviews (Creswell, 2018). Whilst focus groups were felt to be an appropriate method to address the research questions, there was concern that some participants may either not contribute or may not have the opportunity to contribute in detail. Therefore, one-to-one interviews were also conducted with some participants where it was felt that they had further contributions to make that were not raised in the focus groups.

3.4.3 The use of one-to-one interviews

Individual interviews were determined to be an appropriate, complementary method for the issues that needed to be explored with particular individuals following the focus groups. Interviews have been called a *'professional conversation'* and through the interaction between the interviewer and interviewee knowledge is generated (Kvale, 2006). Kvale (2006) warned of the potential power relationship that could exist in this interaction that needs to be made transparent to the reader in order for them to assess its potential significance when considering the research findings. This is very pertinent in the resilience and student midwife study, as I was well known to the students; the implications of this relationship are discussed in section 3.7.

Care was taken to ensure that the interviews took place in a private room where there would be no disturbances. The participants were aware that the interview could take up to an hour and they selected the time for it to take place. It was important not to rush the participants so they had time to consider their responses and were prompted to expand on earlier contributions.

3.5 The setting of the case study

All of the data collection in the initial and main study was undertaken at my own HEI in the East Midlands region of the UK, within a School of Health Sciences. Baxter and Jack (2008) considered it vital for the researcher to be able to determine the unit of analysis and be clear about how to delineate the case. The setting of clear boundaries for the case study should clearly indicate what will be and what will not be included in the study. The participants were across two cohorts but were undertaking midwifery clinical practice within the NHS, in different Trusts.

3.6 Ethical considerations

It is key that ethical issues were considered continuously throughout the research, including the anonymity of the institution and the participants. Ethical issues may arise relating to maintaining the anonymity of the organisation and the participants. It is argued that trying to preserve the anonymity of the institution is challenging as readers of the research could identify the institution should they wish to (Floyd and Arthur, 2012).

Ethical approval to conduct the initial and main study was sought and obtained from the Open University's and my own institution's ethics committees. The only amendments that were required concerned some slight wording change to the participant information sheet (see appendix 2) and that the amended questions' schedule for the main study be sent to the Ethics Committee when finalized, following the initial study.

Emails were used rather than face-to-face contact for participant requests. The use of emails gave the students the opportunity to decline involvement more easily. To adhere to ethical principles, all participants in the initial and main studies were provided with a

participant information sheet describing the research study and what they would be agreeing to if they wished to take part (see appendix 2). The participants were assured that confidentiality and anonymity would be maintained. The student midwives were given the opportunity to ask any questions of myself about the study and they confirmed their agreement to take part in the study by signing and returning a consent form (see appendix 3). Gibbs and Costley (2006:244) discussed the '*ethic of care*', which demands that ethical considerations are addressed, and not ignored, once official ethical approval has been gained. Due to the longitudinal nature of the study and the time lapse between data collection, the participants were referred at each stage to the participant information sheet again prior to conducting the individual focus groups. This ensured that they still fully understood their involvement and that ethical considerations were not neglected whilst undertaking the research itself (Floyd and Arthur, 2012).

The participants were assured that confidentiality and anonymity would be maintained. The participants were aware that they could withdraw from the study without prejudice to their midwifery programme. Assurance was given to the participants that all recordings and paperwork would only be accessible to the researcher and supervisors, and would be stored in a locked filing cupboard. All data was to be stored on a computer, which was password protected, and would be destroyed or deleted at the end of the study.

The location for the conduct of the study was in the Division of Midwifery. A small meeting room was booked for the completion of the resilience scale and the focus group; a private office was used for the one-to-one interviews. There were no safety issues for the participants as although the meeting room was quiet it was located near to a busy work area. The participants were seated around a table

with refreshments provided. It was important to encourage the participants to feel at ease and facilitate trust to share their views and experiences. Reflecting McLafferty (2004), the participants were reassured that they could be open and honest in their contributions without fear of repercussions. For ease of transcription, permission was sought to record the sessions, which none of the participants refused.

3.7 Insider-researcher and implications for this study

It was recognised that for the purpose of this study I was an insider-researcher. Unluer (2012) stated that an insider-researcher has the advantage of knowing how the institution functions and is familiar with its internal politics. As a result of working in the setting, it was found to be efficient in being able to collect the data and being able to access the participants when mutually convenient as there was not the need to await requests going through a third party.

Being an insider-researcher for this study enabled me to identify with the '*language of midwifery*' as the terminology used by the participants was understood. There was also familiarity with the power relationships that the students described, both formal and informal, within the university and the clinical placement settings.

The term '*role duality*' describes how the researcher needs to balance their varying roles within the organisation while also adopting the role of researcher (Unluer, 2012). The intention throughout the research was to try to keep my roles separate to avoid a potential conflict of interest. I had a senior role within the organisation and had to deal with a range of student issues, including ones that were of a very sensitive nature. I had taught sessions with the study cohort but did not know the participants well. As an insider-researcher I did not want to be in a position where I was offering regular pastoral support or

undertaking clinical assessments with any of the participants. It was recognised that I belonged to the group, in terms of being a midwife, knowledgeable and experienced in the midwifery clinical practice environment. Due to being a midwife it was recognised that the participants might state things they thought I would know and make some assumptions of what I was *'wanting'* to hear. I paid particular attention, throughout the focus groups and one-to-one interviews that my questioning technique was clear and if there was any doubt further clarification was offered. As a senior midwife in the institution, I was cognisant that the students' responses might have been affected with the knowledge that ultimately I confirmed their suitability to be added to the register as a midwife with the regulatory body.

Smyth and Halian (2008) suggested that the insider-researcher might unwittingly make the participants feel obliged to be involved in the research. I was aware that due to my position in the midwifery division the participants could potentially have felt coerced or obliged to take part in the study, particularly when the request for the second set of data collection was sent. I was also mindful that I had access to privileged information such as some personal circumstances that they had discussed with me during the course to date. Breen (2007) highlighted how some insider-researchers make specific efforts to reduce the power differential between themselves and their participants.

Burke and Kirton (2006:2) suggested that the insider-researcher is involved in *'developing more nuanced and complex understandings of educational experiences, identities, processes, practices and relations'*. It was recognised that a range of sensitive issues or information affecting participants may be raised during the process of data collection and that support may be required. If it had been identified that any study participant was distressed in any way, as a result of

discussing any issue during data collection, arrangements would have been made, if the student agreed, for support to be given by myself or another midwifery academic such as their personal tutor.

Drake and Heath (2011:28) described how the insider-researcher cannot *'unhear'* what participants have said, which may be of significance in the future. The participants were made aware that as a registered midwife I have to adhere to the NMC (2015) Code and would need to break confidentiality if I became aware of any information that could affect a woman's safety.

Kvale (2006:212) called the qualitative researcher's approach to acknowledging bias as '*perspectival subjectivity*'. As the study participants were describing their experiences from their own perspectives and context, it was acknowledged that biases might have been present; this was considered as the data were analysed.
There is a risk that an insider-researcher may have access to sensitive information but may not receive or *'see'* information from the participants that may be key to the research. I was cognisant that this study presented a challenge for myself as an insider-researcher as I was familiar with the information that the students were sharing. Additionally, the students were likely to be aware of my knowledge base and, as a result, may not have provided detailed explanations.

Burke and Kirton (2006) stressed the importance of insider-researchers undertaking a process of reflexivity to be able to question any assumptions that are made in relation to the research process. Reflexivity enables the researcher to consider how the research is situated in complex social relationships and discourses. Adopting a reflective process helped in this study to acknowledge any prior knowledge and the potential influence it might have on my perceptions of the data (McGhee et al, 2007). Additionally, I reminded

myself repeatedly during the study, particularly during the fieldwork, of the researcher role I was adopting in an attempt to reduce any potential bias as much as possible.

It was imperative to be mindful about the importance of being aware of my interpretation of the data. A reflexive approach was adopted to ensure I was being transparent throughout the research process and to reduce my potential influence on the study results (Smith, 2008).

3.8 The initial study

The initial study took place in December 2015 and was aimed at testing the different methods of data collection proposed for the main study (Williams, 2016). This included the administration of the True Resilience Scale©, the piloting of a focus group and one-to-one interview questions. As a result, the questions asked in the interviews were slightly modified for use in the main study.

The initial study involved the following four activities:

1. The completion of a demographic form
2. The completion of the True Resilience Scale©
3. A focus group was conducted which lasted just over an hour
4. Five relatively short individual semi-structured interviews were conducted. Four interviews were conducted immediately following the focus group and one a week later at the participant's request

Purposive sampling was the approach adopted to select the sample for the initial study (Braun and Clarke, 2013). The participants were accessible as they were all current student midwives, in the same cohort, on an undergraduate programme in the study setting, who

responded to an email inviting participation. The intention for the initial study had been to recruit 10 participants to complete the True Resilience Scale© and participate in the focus group and individual interviews. Five second-year student midwives volunteered to be part of the initial study by responding positively to an email sent in November 2015 to the whole cohort of 45 students. To avoid any conflict of interest, three of my personal students, who were members of that cohort, were told at the time of the email request that they were not eligible to be part of the study. Four participants in the initial study had commenced the midwifery programme at the same time. A further student, who had originally commenced the programme in an earlier cohort, but had recently joined the current cohort, also participated.

There were no missing data; all demographical details had been provided, all scales were complete and no scores were marked more than once. The five scales were manually calculated and recorded, and checked again for any out of range values, i.e. greater than six or any miscalculation of scores. An Excel spreadsheet was used to record the demographic data and the results of the True Resilience Scale©. All five focus group participants were invited to participate in a one-to-one interview and all five agreed.

On completion of the scale and the focus group, all five participants were invited to undertake a one-to-one interview to explore any issues of interest that had been raised in the focus group.

The data gathered from the focus group and the one-to-one interviews, from the different collection points, were analysed individually and then integrated; the purpose of this was to ensure that the data was analysed as a whole. It was recognised that this was a small pilot and the findings can only be indicative.

3.8.1 Findings from the initial study

Wagnild (2014) described how the True Resilience Scale© has been used with many different groups and across all ages but not, up to this point, with midwifery students. There was some evidence in the data set from the scale that the participants had developed their resilience during the midwifery programme and had strong views about it as an important trait.

The participants all described themselves in the focus groups and one-to-one interviews as being resilient, although this was being tested by the demands of the midwifery programme. They were familiar with the term resilience, and clearly described the traits of someone they would deem to be resilient (Werner, 2012; Ungar, 2008; Masten, 2001; Santos, nd) and the characteristics of resilience that they felt they possessed. Resilience was seen by these student midwives as an *'umbrella'* term, by which they meant a '*blanket'* term to cover the different elements that students used interchangeably to get through the programme. *'Resilience styles'* was a subtheme that emerged from the participants' contributions to illustrate how diverse the features of resilience are. Additionally, the participants compared and contrasted themselves with others, in order to verify their experiences of the programme. They gave examples, which implied that certain personalities were better suited to being a midwife. For example, they stated that a student midwife should be able to empathise with others; this theme was one that needed to be explored in more detail within the main study.

The participants' demographic details were considered alongside the resilience scale scores but the profile of the initial study participants was found not to be representative of student midwife cohorts. For example, the age range of the student midwives in the initial study was between 20 and 25 years and, therefore, the average age profile

did not meet that of an undergraduate student midwife (RCM, 2011). Therefore, it is recognised that the findings of the initial study may not be representative of the wider student midwife population. For the main study, the recruitment of a cohort that reflected the average age profile was considered.

3.8.2 Lessons learnt from the initial study

The question schedule was slightly revised following the initial study (see appendix 5), in order to give the questions more clarity.
I gained analytical insights during the data collection and analysis phases of the initial study, and insights in relation to the research questions that were considered for the main study. Braun and Clarke (2013:58) warned of the phenomenon of the *'usual suspects'* who may be involved in research. The profile in this study did not necessarily represent the wider student midwife body; this was acknowledged when considering generalisation of the findings. The five volunteers all had over one year's experience of being a student midwife so it was felt that they could offer good insight into the realities of being on the midwifery programme.

The one-to-one interviews provided the opportunity for the participants to raise more examples of what enabled them to cope that had not been explored in the focus group. Four participants were interviewed immediately following the focus group and one student returned a week later at her request. It is recognised that not having a gap between the two activities may have affected the participant's responses. As a result, in order to achieve consistency for the main study, all the one-to-one interviews were conducted by negotiation with the individual, but with a gap in time from the focus group.

The initial study also provided me the opportunity to test the suitability of the selected methods including becoming familiar with

using the True Resilience Scale©. A process for record keeping for the study was also developed, particularly in relation to recording the participants' responses. It was important that the records could be attributed to the individual participants to be able to subsequently assess trends and make comparisons between the data collected. The initial study enabled me to develop a systematic approach to how I referenced all the data.

Additionally, as a result of running a focus group and conducting the one-to-one interviews, I became particularly aware of my verbal responses to the students and resolved to reduce the amount of verbal interventions I made that could have affected the participants' responses. These insights enabled development in my style of facilitation and interviewing, to be taken in the main study, which included more silences on my part.

3.9 The main study

3.9.1 Sampling for the main study

The participants were different between the initial and main study. The study cohort was selected purposively as it was important to involve a group of student midwives who would be best able to participate for the duration of the study, namely 18 months. One first year cohort that had commenced the undergraduate midwifery programme in that academic year was identified as a suitable cohort. Two months following the commencement of the programme, a direct email was sent to the whole cohort asking for volunteers to take part in the study; half of the cohort (25) expressed an interest in participating. Recruitment occurred at the end of the first seven-week period of theoretical study in the university. Once the participants had volunteered the aim was to commence data gathering prior to their first practice placement so that any potential impact of placements could be captured.

It was recognised that the participants were not necessarily representative of the whole cohort of student midwives; some may have had particular characteristics not displayed in the rest of the cohort. However, the cohort was diverse in terms of age, ethnicity and type of qualifications completed to meet the entry requirements onto the midwifery programme and so was the sample of participants. The students had received a workshop exploring resilience during the first theoretical module. The rationale for the participants volunteering to be part of the study was not explored, although some participants did share that they were interested in the concept of resilience. The study cohort was made aware that they would not be prejudiced on the midwifery programme if they withdrew from the study for any reason.

A total of seven students from the initial 25 had to withdraw from the study due to leaving the midwifery undergraduate programme.

3.9.2 Data collection methods

Five forms of data collection methods were undertaken in this study:

1. The completion of a demographic form by participants
2. A review of their assessment grades over the first 18 months of the programme
3. The completion of the True Resilience Scale© on three occasions
4. Two sessions of four focus groups with the same participants, six and 18 months into the programme
5. Six one-to-one interviews conducted at six and 18 months into the programme.

Moravcsik (2014) argued that detailed description is required to aid the transparency, precision and rigor of any study. This author

particularly criticised studies that do not provide sufficient details of how the data were generated, including the exact questions that generated the findings, the number of focus groups that took place, how they were executed as well as how many individuals participated.

At the commencement of the study, the participants' biographical information was collected to compare with the survey scores. The aim behind comparing biographical information with the results of the survey was to determine whether there were any links between individual characteristics and their resilience scores. Midwifery programmes are graded academically in theory and in practice (NMC, 2009); the participants' assessment grades over the 18-month period were also reviewed when all other data had been collected. This additional information provided data that made it possible to consider how well the students were progressing on the programme and whether any academic or practical challenges were associated with their personal assessments of their resilience.

3.9.3 The demographic data of the main study cohort

In order to describe the sample, a demographic form was devised (APA, 2010). The participants' age, previous employment, marital status, entry qualifications, first year grades, '*home*' and '*away*' Trusts were collected. The majority of the demographic information was gained from the participants' personal files, following consent being received from the participants. Prior to commencement of each of the focus groups, the participants were asked to check their form and finish completing any missing details.

The age range was 18-45, with a mean age of 24 years. Fifteen participants described themselves as single, seven were married and three had partners. The range of previous employment was as follows: four had not had any previous employment; seven had worked in

retail, including one in floristry; one participant had been and continued to be an entertainer; one had been a hairdresser; nine had worked in catering; three had been carers, one had been a teacher; two had been managers; one had been a warehouse operative and one had been an administrator with Social Services.

3.9.4 Timescale of data collection

The timescale of the data collection was between November 2015 and March 2017 (see table 3). Prior to the 25 participants going into clinical practice for the first time in November 2015, biographical details were collected and the True Resilience Scale© was administered for the first time. November 2015 was just prior to the students going into midwifery practice for the first time, therefore, administration of the True Resilience Scale© at this point provided a baseline for future results. The students showed genuine interest to be part of the study. They did not appear to be concerned about my presence nor that they were being audio-recorded. The students were grouped around a table with refreshments to encourage them to feel relaxed whilst I sat back slightly to one side of the group. From my observations of the focus group they engaged with each other and did not refer to me particularly during the exchanges.

Method and number							
Date	True Resilience Scale© completed (Yes/No)	No.	Focus Group (Yes/No)	Number of focus groups conducted	Number of participants	One-to-one interviews	No.
Nov 15	Yes	25	No	0	0	0	0
May 16	Yes	22	Yes	4	22	Yes	4
Mar 17	Yes	18	Yes	4	18	Yes	2

Table 3: Timescale of data collection

In May 2016, eight months into the programme, following two clinical placements, the second stage of data collection took place with 22 participants remaining in the study. In March 2017, 18 months into the programme, when the final data collection occurred, 18 participants remained in the study. The timings of the data collection were spaced to provide data at certain points in the programme; the limited timescale of the doctoral study necessitated this study to be completed within the first 18 months of these students' programme.

3.9.5 Administration of the True Resilience Scale© in the main study

The True Resilience Scale© was administered immediately prior to the participants' first midwifery practice placement week, commencing in November 2015. The rationale for the timing of the first completion of the True Resilience Scale© was to avoid any potential influence that being in clinical practice might have on how the scale was completed. I wanted to gain a baseline measurement for the resilience scale with which to compare responses when completion of the scale was administered at two further points during the study. The participants completed the quantitative resilience measurement tool on three occasions in total: at the commencement of their programme (November 2015), after eight months (March 2016) and after 18 months (May 2017). The completion of the tool with the same cohort on the three occasions throughout the study period generated data that determined what changes there were in how they reported their resilience over the 18-month period. The participants took part in focus groups, following the completion of the tool, on the second and third occasions.

The True Resilience Scale© was used specifically to answer one of the research's questions, namely, to what extent is the development of resilience in the first 18 months of a three-year undergraduate

midwifery programme a factor in a student's ability to navigate the undergraduate midwifery programme?

3.9.6 The main study focus groups

Engaging a group in discussion is key to the success of the focus group, rather than individuals simply answering the questions one by one (Guest et al, 2017). The group interactions are important in focus groups and can be the key component within the data set. I recognised that people work and present themselves in a group in a variety of ways. While facilitating each focus group, I was mindful of the need to be cognisant of how the group was interacting and whether all members of the group had the opportunity to contribute. Hennink et al (2011) described the personality types that can emerge in a focus group, namely: a quiet participant, a dominant participant, a rambling participant and a self-appointed expert. The management of groups can be challenging if participants are too domineering or too quiet and the purpose of the focus group may be lost. The facilitation of group dynamics is key to ensuring all participants have an opportunity to contribute. Once the trigger question was posed I kept quiet to allow the conversation within the group to flow. I also observed the group dynamics as they responded to the questions. I found myself, on occasions throughout the focus groups, returning to something that had been raised earlier by an individual to ensure their point was not lost or misunderstood. I observed that the participants did not defer to me during the discussion and visibly looked at each other, as each took their turn to speak.

The participants took part in focus groups at the nine month and 18-month stages of the study. I facilitated the focus groups using a partially structured question schedule to encourage the group to start the discussion and only then spoke to ask further questions if I needed to clarify what was being said. Each phase of the focus groups

had a different question schedule to reflect the stage in the programme that the participants were at during the fieldwork.

Each focus group conducted contained a range of between four and seven participants. One focus group included one participant who dialled in on a telephone that was on loudspeaker so that they and all that were present in the room could hear their contributions. I did not perceive any noticeable difference in the overall dynamics of the group with one participant contributing remotely, other than that the group needed to be more explicit in taking turns to speak.

The same group composition was used for the second round of focus groups in order to build on the data at each stage of the fieldwork. However, on the day of the focus groups some group membership was adjusted in groups one and two; there were some original members alongside some other participants who could not make the original time slot allocated to them. The purpose of trying to retain the same group membership for both focus group sessions was to promote interaction in a familiar group and so they could remind each other of what was previously discussed. Additionally, keeping the same group membership enabled the group's experiences to be compared over time. The composition of the group did not appear to affect the discussion that took place. It appeared that the students were relaxed in each other's company, contributed to the discussion and were eager to share their experiences.

I was interested in how a participant would describe and share their understanding of being a student midwife from their perspective and in the interaction between them in order to identify whether this generated any additional insights in relation to the research questions (Kevern and Webb, 2001). The participants in the study were from one homogenous all-female cohort, with common experiences and

backgrounds of student midwifery practice; this potentially had a positive impact in this study on what they were willing to share, particularly concerning sensitive information (Kreugar and Casey, 2015). I was mindful that a rapport already existed within the group, with some defined friendship groups, but the initial focus groups were allocated based purely on the volunteers themselves signing up for a specific time slot. However, the participants in each group reported that they did not know each other very well and stated that this enabled them to speak more freely than if any of their close friends had participated in the same focus group.

The focus groups in this study ranged in length between 23 and 59 minutes. I had forewarned the participants in advance that the focus group could take up to an hour so that they were aware of the commitment involved; this reflects ethical and good practice. The length of each focus group was determined by how long the participants took to respond to each of the questions posed and when saturation seemed to have been reached and no further contributions were being made.

3.9.7 The use of one-to-one interviews in the main study

One-to-one interviews were conducted at the nine and 18-month stages of the programme, following each focus group.
The interviews provided a good way of probing the thoughts, perceptions and experiences of the six participants. The selection of the six participants was made based on them having raised something of interest in the focus groups that warranted further exploration. For example, two students seemed to have slightly opposing views: one articulated the concept of resilience very clearly and the other seemed to doubt her own resilience.

I used an interview question schedule in a semi-structured way as well as asking specific questions relating to the student's earlier contributions in either the focus groups, the resilience scale completion or when clarification was required (see appendix 5). I encouraged the interviewee to further describe their understanding of resilience in order to assess the significance of this concept to a student midwife. I finalised the questions to be asked for each one-to-one interview just prior to the session, as they were individual to the particular student selected.

3.10 Transcription of the data from the focus groups and the one-to-one interviews

Following each focus group and one-to-one interview, the audio recording was transcribed. The style of transcription that was used reflected Braun and Clarke's (2013) approach, whereby they had adapted a model developed by Jefferson (2004). For the audio recordings of all the focus groups and one-to-one interviews, the approach was orthographic (verbatim). My focus, during the transcription, was on the spoken words of the participants. In my field notes I meticulously detailed who was speaking so that I could align the spoken contributions to the individuals as accurately as possible. This was key in order to replicate the focus group membership between the phases of the data collection, to cross-analyse the data and to answer the study's research questions.

Once I had undertaken the detailed analysis, each participant was given a pseudonym to ensure anonymity was preserved. I transcribed each focus group and one-to-one interview as soon after the event as possible so that the details of the event remained clear. The only exception to this was when any NHS Trust names had been stated I allocated a pseudonym to preserve anonymity. Throughout the transcription, I used headphones to ensure that anonymity of the

participants was maintained and that the confidentiality of their contributions preserved.

3.11 Data checking

The repeated listening to the audio recordings enabled me to immerse myself in the data and, as far as possible, transcribe what was being said to create a careful record. I prepared a table for each transcription, noting any aspects of interest in a separate column. I became conscious that I was undertaking some preliminary analysis as I proceeded and I was noticing things that were of interest to the research questions.

Being about to identify the individual participants throughout the research study was key in order to be able to cross-verify the data set and establish if they were to be invited to participate in one-to-one interviews. I had to ask one of the participants to help identify, on the recording, two of the participants in their focus group due to their voices sounding so similar. As a result, I adopted a different written system in the next set of focus groups to ensure I had a way of correctly identifying the different participants.

3.12 The process of analysis of all data

An Excel spreadsheet was used to record the demographic data, the assessment scores and the True Resilience Scale© results to consider whether there were any visual links or trends between the data. The score for each question was manually totaled, and then divided by the number of participants who had completed the questionnaire; this revealed the mean score for each question. Additionally, the average overall score for each scale the individual participant completed was gained by adding together each score and each question, then dividing it by the total number of questions completed. An assessment

of the trend in the scores, of the three scales completed over the 18-month period was also made.

To assess the potential usefulness of the True Resilience Scale© results for student midwives, a sample of scores from high to low were compared with what the individuals had discussed in the focus groups.

On completion of the transcription of all focus groups and one-to-one interviews, analysis was conducted across all the data sets. Analysis is not a discrete activity at one stage of the research process but an *'iterative'* one that continues throughout the study, from when the data are collected to the writing up stage (Green, 2014:139).

The initial and main studies used Braun and Clarke's (2013) stages and codes of thematic analysis to analyse the data. Their practical guidance supports a systematic approach to analysis in order for *'analytical sensibility'* to ensue (Braun and Clarke, 2013:201). Additional analysis was conducted to specifically look at the role that interaction played in relation to the participants' responses.

My aim throughout the analysis was to be systematic and thorough (see table 4). Kreugar and Casey (2015:139) supported this approach stating that analysis should be *'systematic, verifiable, sequential and continuous'*. Additionally, insight should be gained that could be used to guide the analytical processes, for example, patterns, meaning or links to broader psychological, social or theoretical concerns (Braun and Clarke, 2013). The importance of adopting a position of inquiry towards the data throughout was recognised.

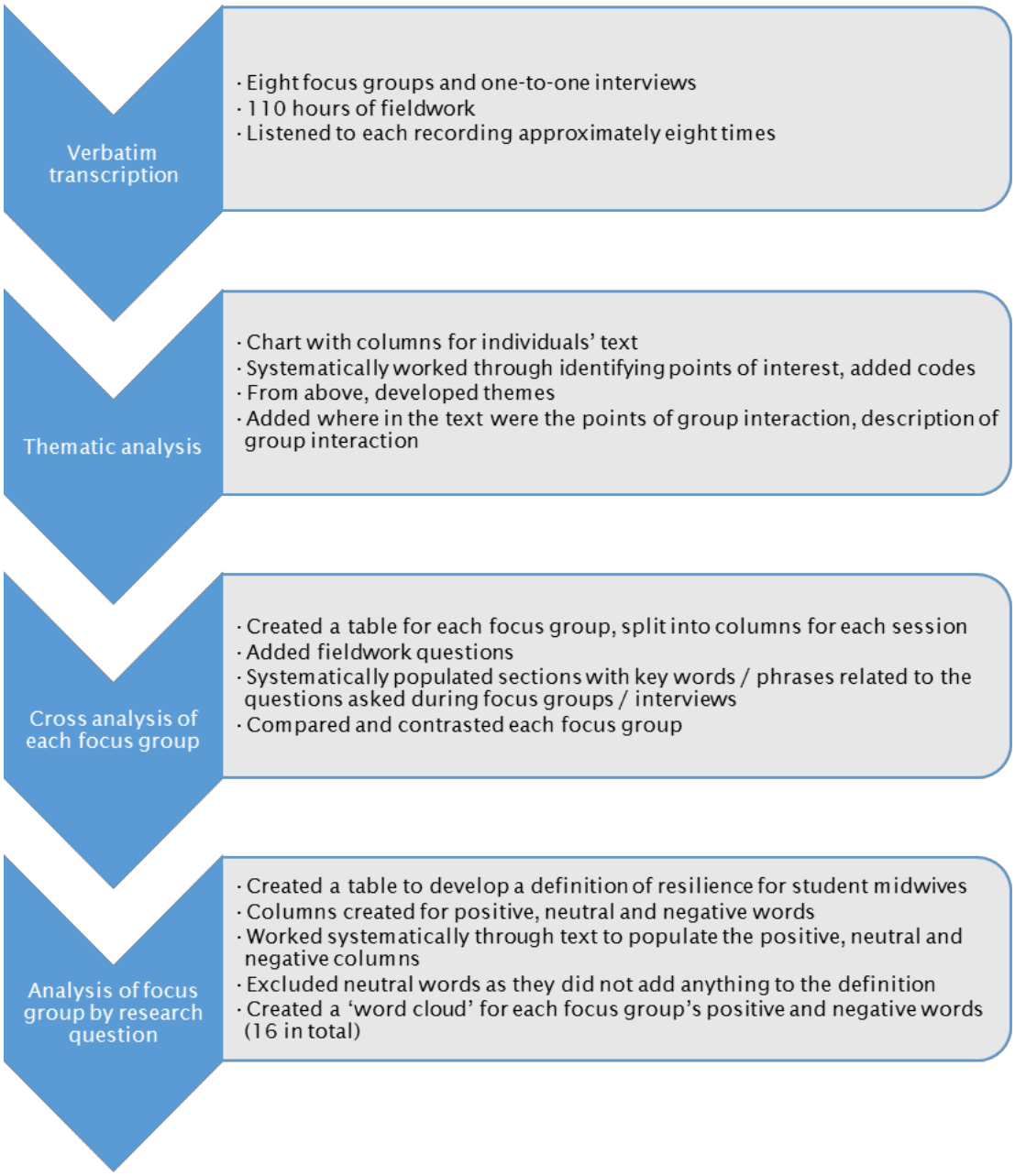

Table 4: Process of data analysis

Braun and Clarke (2013:211) stated that coding is an *'organic and evolving process'*. Codes should also capture the *'qualitative richness of the phenomenon'* (Boyatzis, 1998:1).

Complete coding was used where words and phrases were identified within the data, with the aim of determining anything of relevance to the study's research questions and applying labels (see appendix 6). Therefore, once the first coding of the dataset was complete in this

study, the whole data set was systematically revisited looking for chunks of data that could be re-coded. Additionally, Stevens' (1996) set of questions were used as a guide to analyse the focus group data (see appendix 7). Thereafter, I worked with the codes to identify broader patterns that could ultimately be grouped into themes.

I adopted thematic analysis as the method to identify themes and patterns across the data set, using the flexibility of Braun and Clarke's approach (2013). These authors provided a clearly outlined set of systematic procedures to adopt during the analysis phase. They argued that it is an accessible method to both the researcher and a wider audience. A theme is said to be a *'centralising organising concept'* containing different ideas or aspects of the coded data (Braun and Clarke, 2013:224). These authors do not agree that themes simply emerge from the data but rather that the researcher is active in discovering them as the codes are examined.

Cyr's (2016) discussion raised the importance of the interactive unit of analysis. Additionally, it is important in the analysis of the data to consider whether the group members are working together to come to a consensus, or if one member of the group dominates, how the group membership deals with this. In response to this, some additional analytical steps were used to look at the interaction within the groups.

In order to analyse the group interaction Stevens' (1996:172) questions (see appendix 8) were followed. These questions provided a useful framework to work with to move from simply reading the transcripts to considering some of the meanings in what the participants were expressing.

Subsequently, key themes were identified that were mapped across all the focus groups and one-to-one interviews. In the focus groups data I took note of the group interaction that was occurring, for example: agreement and concurring, continuing the theme and completing each other's sentences. Stewart and Shamdasam (2014) also argued that the strength of focus groups was how the interactions between the group members generate more information and how they accept or reflect each other's ideas. Therefore, the non-semantic sounds, for example, pauses, laughter, and repetitions were seen as important as the words spoken; this included the empathy the focus group participants had for one another's situation and experience. The students answered the questions that I posed, but their detailed responses sometimes meant that they needed to be refocused to bring them back to the question. An example, based on Braun and Clarke (2013), of how the themes emerged from the initial codes is illustrated in appendix 9.

3.13 Transferability of the study

Lincoln and Guba (1985) proposed the following four criteria to assess the rigour of qualitative research findings, namely: credibility (the value and believability of the findings), dependability (how stable the data are), confirmability (neutrality and accuracy of the data) and transferability (whether data can be transferred to another context).

The term generalisability denotes whether the results of one study can be applied to a wider population (Braun and Clarke, 2013). Transferability is a term that is now being used more frequently to align with qualitative research results to describe how results can be applied to other contexts or participants (Lincoln and Guba, 1985). Transferability relies on providing *'thick'* description, with the research being described in detail, so that the reader can determine whether the findings can be transferred to their own context

(Houghton et al, 2013). The *'thick'* description should include the research methods used and examples of how the data were interpreted. In the resilience and student midwife case study *'thick'* descriptions have been given to enhance the transferability of the study findings to the wider student midwife population.

3.14 Conclusion

This case study used five methods to gather data, namely: demographic data, assessment scores, a resilience survey tool, focus groups and one-to-one interviews. The use of different methods enhanced the potential for the in-depth insight and completeness of the data set. The initial study provided an essential opportunity to test the methods, and key insights were gained for the main study; not least, the conduct required by the facilitator when facilitating focus groups.

Ethical considerations have been paramount throughout all stages of the research, with the issue of being an insider-researcher requiring particular attention. The data analysis adopted varied across the methods used and has been detailed in this chapter.

It is suggested that the case study can provide information that can be transferred to the wider population of student midwives. Midwifery student programmes within the UK have to reflect the standards set by the regulatory body, the NMC (2009), and their experience within the NHS around the UK is likely to be broadly similar.

Chapter 4.0 Findings

4.1 Introduction

This chapter presents the findings from the research study.
The True Resilience Scale© has been descriptively analysed with results inputted via SPSS version 24. All of the True Resilience Scales© have been combined to present the trends in the resilience scores across the study cohort; this enables the differences between the different question responses to be observed. The True Resilience Scale© results have been compared and contrasted with the demographic findings and the assessment scores and the contributions of a sample of participants in their focus groups. The data from each focus group and all the one-to-one interviews have been thematically analysed, these themes and a selection of direct quotations from the participants included. Firstly, what the concept of resilience meant for this group of student midwives and their practice will be considered. Secondly, the data presented demonstrate that there was repeated reference throughout the study that a student midwife needs to be resilient and the essential features to achieve this trait. Thirdly, the participants gave detailed descriptions of what supported their development of resilience and what threatened it.

The data suggest that the majority of this group of student midwives did develop their resilience over the course of the study and were committed to completing their programme, which they revealed through the True Resilience Scale© results, the focus groups and the interviews.

4.2 The findings of the True Resilience Scale©

In table 5, below, Wagnild and Young's (2015) True Resilience Scale© questions are presented alongside the findings across all three

occasions that the 18 participants completed the scale. The mean score for each administration of the scale and the total mean for each question are displayed as well as the trend across the second and third administration. It should be noted that the column displaying the trend provides a simple visual representation of whether the scores reflected an increase, decrease or static score and not an accurate depiction of the change.

No	Question	1	2	3	Trend	Mean for each item
1	If something is worth starting, I'm going to finish it	5.3	5.5	5.6	↑ ↑	5.5
2	I depend on myself to find a way of surviving	4.2	4.6	5.3	↑ ↑	4.7
3	I stay true to myself even when I'm afraid to do so	4.3	4.9	4.9	↑ ↔	4.7
4	I know why I'm on this earth	4.5	5.1	5.0	↑ ↓	4.9
5	My deeply held values guide my choices	5.0	5.1	5.0	↑ ↓	5.0
6	Every day I do something that is meaningful to me	4.0	4.5	4.5	↑ ↔	4.3
7	I can see most situations from different points of view	4.9	5.5	5.4	↑ ↓	5.3
8	I'm honest with myself when something is wrong with me	4.6	4.8	4.7	↑ ↓	4.7
9	In a time of trouble, I figure out what needs to be done	4.3	5.0	4.8	↑ ↓	5.1
10	Even if don't feel like it, I do what I need to do.	4.6	5.9	5.2	↑ ↓	5.2
11	Looking back at my life, I feel satisfied	4.7	5.5	6.3	↑ ↑	5.5

12	I'm not upset for too long when life doesn't go my way	5.0	4.9	5.2	↓ ↑	5.0
13	I rely on myself to do what is right for me	3.8	4.9	4.9	↑ ↔	4.5
14	I am determined even if the odds are against me	4.8	5	4.7	↑ ↓	4.8
15	I am excited about the plans I have	5.6	5.5	5.6	↓ ↑	5.6
16	I remain calm under pressure	4.6	5.0	4.8	↑ ↓	4.8
17	I make decisions that are consistent with my beliefs	4.5	5.1	4.8	↑ ↓	4.8
18	I often tell myself " I can do this"	4.8	5.2	4.3	↑ ↓	4.8
19	I can find something positive in whatever happens	4.6	5.1	4.9	↑ ↓	4.8
20	I see an obstacle as a challenge to overcome	4.5	5.1	4.6	↑ ↓	4.7
21	I can say what I am good at	3.9	4.3	4.3	↑ ↔	4.2
22	I rely on my sense of humour to improve my outlook	4.4	4.5	4.6	↑ ↑	4.9
23	I take responsibility for my decisions	5.2	5.3	5.3	↑ ↔	5.3
24	Disappointment doesn't stop me from trying again	4.8	5.1	5.1	↑ ↔	5.0
25	I know what's most important to me and this knowledge guides my life	5.4	5.5	5.2	↑ ↓	5.4

Table 5: Mean scores and trends of all participants for each resilience scale completion

Key to trends:

↑ increased ↓ decreased ↔ static

4.2.1 Resilience scores for all 18 participants

- Five participants increased their resilience over the 18 months
- Seven participants increased then decreased their resilience over the 18 months
- Five participants decreased then increased their resilience over the 18 months
- One participant increased their resilience and then remained static
- No participants decreased their resilience over the first 18 months

Therefore the majority of students in this did increase their resilience score over the first 18 months of the programme.

4.2.2 Descriptive interpretation of the True Resilience Scale© statements and scores

The highest average score from the 25 statements was 5.5 for the two questions '*If something is worth starting I'm going to finish it'* and '*Looking back at my life I feel satisfied'*. The lowest average score was 4.2 for the statement '*I can say what I am good at*.' Over the three occasions the scale was completed, in this study, seven of the question responses to seven questions increased. One question had the smallest increase from 4.4 to 4.6 over the 18-month period. The largest variation in score over the 18-month period was for two statements, namely: a score range of 4.2-5.3 and 3.8-4.9.
Overall, these findings show that resilience had increased in this cohort of student midwives.

The responses to nine of the statements increased then decreased over the 18-month period of the study and three statements increased, then remained static: Two of the statement responses decreased then increased.

4.2.3 The True Resilience Scale© SPSS analysis

Version 24 of the SPSS package was used to analyse the findings of the True Resilience Scale©. The three completed scales of the 18 students, who continued on the programme, were analysed and included in the data set.

A one-way repeated measures ANOVA, (one-way analysis of variance), was conducted to compare the scores of the True Resilience Scale©, between the first, second and third time of completion. As there were greater than two paired samples, a one-way repeated measures ANOVA test was used. The mean and standard deviations are presented in table 6. Pairwise comparisons revealed that there were significant differences in True Resilience Scale© scores between the first and the second completion (p= 0.034) and time one and time three (p= 0.002); there were no significant differences between time two and time three (p=1.0) (see table 7).

Time period	Mean	Std. Deviation	N
T1	111.94	15.600	18
T2	122.22	7.464	18
T3	123.33	12.815	18

Table 6: Mean and standard deviation for each of the three administrations of the True Resilience Scale©

Time period		Mean Difference	Std. Error	Sig.[b]	95% Confidence Interval for Difference	
					Lower Bound	Upper Bound
1	2	-10.278	3.617	.034	-19.881	-.674
	3	-11.389	2.801	.002	-18.825	-3.953
2	1	10.278	3.617	.034	.674	19.881
	3	-1.111	2.930	1.000	-8.891	6.669
3	1	11.389	2.801	.002	3.953	18.825
	2	1.111	2.930	1.000	-6.669	8.891

Table 7: Pairwise comparisons for each of the three administrations of the True Resilience Scale©

4.2.4 Biographical details and True Resilience Scale© results

The majority of the students (8) increased their resilience scores over the first 18 months of the programme. Six of the students had an initial increase in resilience score and then the score decreased by half way through the midwifery programme. Four students had an initial decrease in resilience score but then it increased by 18 months into the programme. Only one student's score, which initially increased, remained static. Therefore, although overall the resilience scores increased by the half-way point in the programme, they did so at different rates. The resilience scores and trends were examined in relation to the biographical details of the participants (see table 8).

Student midwife number (remaining 18 months into the study)	Age on entry	Highest entry qualifications	Previous employment	Average resilience score	Trend overall (2nd and 3rd completion of scale)
2	37	Degree	Retail	132	↑ ↔
3	24	Degree	None	127	↑ ↑
4	28	Diploma of Higher Education	None	117	↑ ↓
5	20	BTEC	Healthcare	126	↑ ↑
6	23	Degree	Retail and catering	120	↑ ↓
7	20	BTEC	Hospitality	125	↑ ↓
8	18	'A' levels	Catering	110	↑ ↑
9	30	Access	Beauty	105	↑ ↑
10	20	"A' levels	Catering	127	↓ ↑
12	32	Masters	Teacher	94	↑ ↓
13	31	Healthcare apprenticeship	Healthcare	123	↑ ↑
14	25	Foundation degree	Childcare	124	↑ ↓
16	21	Degree	None	112	↑ ↓
17	22	Access	Retail	121	↑ ↑
19	20	'A' levels	Hospitality / Healthcare	114	↓ ↑
20	19	'A' levels	None	111	↑ ↑
24	22	Access	Retail	127	↓ ↑
25	32	Access	Administration	127	↓ ↑

Table 8: Comparison of biographical details and resilience scores

Within the group of students there was a range of ages, entry qualifications and previous experience in employment. The highest and lowest average resilience scores were in the older participants, i.e. over 25 years of age. Some higher than average resilience scores were in students who entered the programme following an access course, closely followed by a BTEC qualification. The resilience scores were slightly higher in the students who had been previously employed in healthcare.

4.3 Study participants' average assessment grades and the True Resilience Scale© results

The majority of participants were high achievers at the 18-month stage of the midwifery programme. Sixteen of the participants (88.9%) had average academic and practice-graded marks of 60-69% and 70% plus (table 9). On review of the highest average (77%) and lowest average academic score (45%) there was no relationship between a higher or lower True Resilience Scale© result. These were 122 and 124 respectively.

Grade/Mark	Description	Number of participants
A (70+)	Excellent	7
B (60-69)	Very good	9
C (50-59)	Good	1
D (40-49)	Minimum standard	1
E (39 or below)	Fails to meet minimum standards	0
		Total: 18

Table 9: Average assessment scores across the 18 months on the midwifery programme

4.4 Summary of findings of the True Resilience Scale©

The True Resilience Scale© results over the first 18 months of the undergraduate midwifery programme overall demonstrated that the resilience in the majority of this cohort of student midwives had increased, albeit at different rates. SPSS was statistically significant in

terms of whether the students were resilient. A review of the overall scores in relation to age and assessment grades did not appear to be related. Some of the scores appeared to demonstrate some of the traits that may be of interest to remaining on the programme and becoming a midwife. The findings from the focus groups and one-to-one interviews in this study will now be presented.

4.5 Themes from the focus groups and one-to-one interviews

All data collected during the focus groups and one-to-one interviews have been merged and presented in the findings. The findings were not presented separately, as the primary aim of the one-to-one interviews was to further explore topics of interest that particular individuals had raised in the focus groups. The intention was to explore the same topics in the focus groups and the one-to-one interviews. The one-to-one interviews were conducted in a private office, which encouraged the individuals to divulge more than in a group setting.

I observed that overall there was general agreement amongst the participants, concurring with what is being said and there was no conflict. Similarly, there were no contradictions apparent as, in the main, the students were recounting similar experiences. On many occasions the participants completed the sentence or expanded the response of another member of the group. The group members demonstrated in their responses that they were problem-solving the questions and also highlighted that they had encountered similar experiences in practice. Only two students expressed a different viewpoint, but these were tolerated and not challenged.

Through the process of the thematic analysis, the following five main themes and their respective sub themes emerged:

1. The concept and definition of resilience for these student midwives' practice

2. The characteristics of a resilient student midwife
   2a: Emotional awareness and intelligence
   2b: Having passion, balance and the ability to compartmentalise
   2c: Being flexible and adaptable

3. Opportunities to promote and threats to hinder resilience in a student midwife
   3a: The reflexive student midwife
   3b: Approaches to the programme
   3c: The effect of clinical practice and the importance of self-care
   3d: The mature student midwife

4. Reliance and relationships with others

5. Resilience, the student midwife and childbearing women

The relationship of the themes to the study's research questions was mapped to ensure that they had been answered (see appendix 10). The findings within each theme are now presented with a range of anonymised direct quotations from the focus groups and one-to-one interviews participants included.[3]

[3] Key to quotations: St/Mid= student midwife with unique number; FG Focus group with number; Int. = one to one interview; 8 months= eight months into the programme; 18 months= eighteen months into the programme.

4.5.1 Theme 1: The concept and definition of resilience for these student midwives' practice

The student midwives stated that the term '*resilience*' in lay usage implied that a person was not affected by adverse circumstances and that they were '*hard*'; they disputed these definitions and felt that individuals are affected by what happens to them. Participants identified more than one type of resilience namely: physical, emotional, psychological, spiritual, relational and institutional. They all agreed that resilience was needed for midwifery practice, due to its challenging nature; with many things needing to be dealt and coped with. These participants described resilience as being a social construct with different words being used in everyday language to express the concept.

Resilience was cited as being required to have longevity in a midwifery career. The participants stated that individuals had a personal responsibility to be resilient and that they needed to learn how they were affected by things to reduce the impact. Participants defined resilience in the context of midwifery practice and its importance to be able to be an effective student midwife. Resilience was described as a personal and hidden trait in people, but was an essential one to put into perspective the challenging events they encountered in midwifery practice.

> '… what I do myself helps me to be a resilient student rather than you know because of my personal traits or beliefs or whatever…….it's quite a personal thing'.
>
> (StMid16/FG3/8 months)

The three most prevalent words represented in the '*word clouds*' (see appendices 11 and 12) are listed in table 10 and demonstrate the most frequently recurring words across all focus groups.

Focus Group (FG) and time point in the programme	Positive	Negative
FG1 8 months	support, friendship, dealing [with the issue]	wrong, emotional, cry
FG1 18 months	dealing [with the issue], caring, driving	hard, thrown, unapproachable
FG2 8 months	confidence, goal, dealing [with the issue]	Hard, emotions, crying
FG2 18 months	support, adapt, dealing [with the issue]	stressful, crying, emotional
FG3 8 months	Reflect, support, confident	challenging, bad emergency
FG3 18 months	confidence, support aware	hard, challenging, bad
FG4 May 2016	building, help, survive	upset, hard, emotion
FG4 March 2017	dealing [with the issue], being organised, mental health	stressful, awful, tough

Table 10: Recurring positive and negative words in relation to resilience across all focus groups

The following positive words were mentioned most frequently across all focus groups in terms of what promoted resilience: deal, reflect and confidence. All of the groups were very clear that actively '*dealing*' with negative experiences was essential to being resilient as a student midwife in order to avoid becoming stressed and being overwhelmed by problems. The importance of '*dealing*' with issues through the understanding and accepting of the problem calmly was key to the participants so that they avoided becoming overwhelmed, which could lead to being ineffective in practice.

> 'I guess it is being strong enough to deal with adverse things'.
>
> (StMid3/FG1/8 months)

> '….how resilient you are as a student midwife [is] how you deal with the challenging situations and long hours…'.
>
> (StMid17/FG1/18 months)

Additionally, they described resilience as the ability to '*bounce bac*k' and to be able to come back and carry on practising midwifery, even following difficult situations:

> ‘I think it is being able to bounce back when something does not go as expected …..you are going down that slope, being able to get yourself out of it’.
>
> (StMid/16/FG3/18 months)

When asked about what resilience meant to them 18 months into the programme, some of the participants further elaborated:

> ‘Our ability to come back after a fall…a difficult day. Emotional resilience as well’.
>
> (StMid14/FG2/18 months)

> ‘Carrying on, [the] ability to carry on [and] someone who can find strategies and answers and solutions if there is a problem’.
>
> (StMid4/FG2/18 months)

However, resilience was not seen as a constant trait but changing depending on the context in their work and personal lives and would develop throughout the programme in preparation for registered practice. They described the importance of accepting that challenging situations would occur whilst on the programme and that a proactive approach must be adopted to deal with them. The groups also felt that mental strength was required to be resilient, as well as needing to have a belief in oneself.

The concept of resilience was aligned to a person who was ‘*open and honest’* with themselves about how they were feeling about challenges and someone who is able to find strategies to cope with the problems they are faced with:

'I think that's still resilience because it's learning how you are affected by things and its finding like empathy, feeling other people's pain and still being able to support…not just get hardened to it …'.

(StMid10/FG2/18 months)

'…you might need to be a bit more resilient to be a student midwife'.

(StMid14/FG2/18 months)

'Just how well people cope with what goes on within midwifery. There's plenty of people I know in my life who wouldn't cope'.

(StMid4/FG2/18 months)

In terms of the negative words, which could threaten resilience, the following were raised in the focus groups: challenging [in relation to the midwifery programme], emotions [their responses to midwifery experiences] and hard [the work they had to achieve to become a midwife]. Additionally, the participants described a range of upsetting situations that had occurred within their practice experience to date, including fetal loss and emergency situations. They were fully aware of how situations in midwifery practice could change very rapidly and an imperative for them to react appropriately for the women in their care. Additionally, they felt that being able to see things clearly was a key attribute in a midwife and linked to resilience. They gave examples of other people who they described as being resilient such as the coordinators on the delivery suite:

'Sometimes you feel mentally literally exhausted don't you? … and you think, I can't give anymore…but you carry on, you do carry on. You do surprise yourself in a sense don't you?'.

(StMid15/FG1/8 months)

The participants also confirmed that achieving a '*balance*' and a specific '*mindset*' was important. They felt resilience can be learnt and built up, and it was an essential requirement to be an effective student midwife.

> 'Resilience is when you have had a hard situation and you go in and deal with it again …so you'd go back and if you have the same situation you deal with it again and … build that resilience from it…'.
>
> (StMid10/FG3/8 months)

The majority of the participants during the fieldwork described themselves as being resilient. All of the participants remained passionate about midwifery but recognised how stressful it was at times:

> 'It's the positive way in which we can move forward from something possibly that has been a negative experience, taking the positive in the way you arrange to deal with it'.
>
> (StMid25/FG4/8 months)

They felt that the first year had been crucial to developing confidence. Several times the importance of believing that they could complete the programme to become registered midwives and the role resilience played in this was discussed. It was highlighted that it was harder to be resilient if their self-esteem or confidence was low and if there was a lot going in their personal lives. One participant shared that she had accessed a programme within the university, which had been advertised as promoting self-esteem. When asked why she was accessing the programme she responded that she wanted to develop her resilience. The student then discussed about how she felt that resilience had become a concept that focused the attention on the

individual in order to put up with poor behaviour in the workplace, such as bullying:

> '…building resilience was perceived as becoming or doing what other people want you to do and not questioning it. I am resilient so I am not letting the person affect my emotional state…'.
>
> (StMid 12/Int./8 months)

This student described the effect of placing the responsibility on the individual to be resilient to be able to cope with poor behaviours. She described how negative cultures, within the healthcare workplace, were being condoned and, as a result, the definition of resilience was not being used appropriately.

The expression '*straw that broke the camel's back'* was used to describe what happened when things overwhelmed them:

> '…I thought I was resilient but I've realised that I think that I am a lot more resilient now than what I was. I can now just get on with things. Being organised has made such a difference. Like you say, just being on top of things'.
>
> (StMid6/FG4/18 months)

During the second round of focus groups, 18 months into the programme, the participants described how the midwifery programme had personally and professionally developed them. For example, they felt they were more authoritative, confident and assertive:

> 'I've noticed definitely a change in myself…more confident just going into new situations just like not scared'.
>
> (StMid10/FG3/8 months)

> '…I feel I have more confidence to speak more what I think and feel and I see myself now as a professional…people see me differently as well, I think now you know people see me…as a professional'.
>
> (StMid3/FG1/18 months)

Being resilient was seen as an achievement and admirable. They wanted to be able to cope and get through the programme but felt that they needed to set realistic expectations and recognise their limitations and weaknesses:

> 'I think you show poor resilience when you are incredibly overwhelmed and it begins to affect your health, your mental health. The problem isn't being addressed it's just continuing to be there'.
>
> (StMid19/Int./18 months)

> 'Firstly, being aware of the concept. Secondly being given the tools [such as] reflection then I could notice that when I go out into practice. What can I learn from this? Right I will go and do this. Then I was able to demonstrate resilience'.
>
> (StMid19/Int./18 months)

One student shared that she felt she had a strong character, which some people misinterpreted as not caring. Only one student felt that her resilience in general was low, at the time the focus group met for the second time, due to experiencing some difficult personal times.

They recognised that people coped with challenges differently and they needed to deal with situations that they would face during the programme and once they qualified as a midwife. By the time participants were 18 months into the programme they appeared to

have more recognition of what was required of them to be resilient on the midwifery programme. One student specifically shared that she felt her resilience had been challenged while she had been on the programme, but the fact she was continuing perhaps demonstrated that she did indeed have resilience:

> 'I've had a tough few months and resilience has been tested to the extreme…I am not feeling resilient…but I am still here so I must have some resilience'.
>
> (StMid12/FG4/18 months)

4.5.2 Theme 2: The characteristics of a resilient student midwife

The participants in this study described a number of characteristics that a resilient student midwife required. An individual's personality was discussed as being potentially significant for a student midwife to be able to be resilient. As well as being confident, accepting and being able to handle situations, the students described the need to also be adaptable, flexible and proactive in midwifery practice. The participants shared how they would describe someone who was resilient in midwifery and what characteristics could be attributed to them, for example to be able to control their emotions:

> '[They were] controlled in their emotions and they've got a sense of clarity and then can just see things clearly'.
>
> (StMid5/FG1/18 months)

A key thing seemed to be having self-awareness to accept what was going on and dealing with it. Keeping the goal of becoming a midwife was also described as being very important when dealing with adverse experiences:

> ‘You’ve just got to keep reminding yourself of the broader picture. This is what’s going on now, in a few years’ time its’ what’s happened now is towards that end goal’.
>
> (StMid14/FG2/8 months)

> ‘One step at a time. I just do that, one week [at a time]; if I look ahead it gets too much. If you just take small steps you do achieve don’t you?’.
>
> (StMid21/FG2/8 months)

The participants discussed the following personality traits in detail, namely: having emotional awareness and intelligence, having passion, balance and the ability to compartmentalise, and being flexible and adaptable.

- **Sub theme 2a: Emotional awareness and intelligence**

Within a short time of starting the programme the participants felt they were experiencing a change in their emotional reactions and the importance of needing to control one’s emotions when with the women. They felt they were emotionally labile and discussed the role of emotional intelligence as key attributes requiring development:

> ‘How your emotions can go up and down but finding a balance and a level and you carry on’.
>
> (StMid21/FG2/8 months)

> ‘And knowing you own emotions and being able to handle them in situations where you might find it a bit difficult’.
>
> (StMid2/FG1/8 months)

The emotional work of midwifery was considered at length. The students had witnessed many different reactions by midwives when upsetting events had occurred and how this was connected to resilience:

> '…I saw the emotions of the midwives. They were just able to deal with it… I think everyone's ability to deal with situations is going to be different'.
>
> (StMid25/FG4/8 months)

The labiality of their emotions had taken them by surprise but they recognised that everyone's ability to deal with their emotions was different. The participants agreed it was important to accept the emotions they were feeling, to be able to deal with them, which in itself showed resilience and described how they were learning to cope and control their emotions:

> '…you can still show your emotions and be an emotional person. I think it is how you deal with your emotions…that shows your resilience'.
>
> (StMid24/FG4/8 months)

It was agreed by the participants that a midwife can show their emotions and move on either by learning something from it or changing their actions. One group used the analogy of a '*rollercoaster'* to describe their emotions and what happened when dealing with things in clinical practice was discussed at length:

> 'I think it is a rollercoaster of emotions this course...through this course you develop…'.
>
> (StMid13/FG1/18 months)

The second time the groups met, 18 months into the programme, the participants described that they had '*grown'* emotionally:

> '…in the first year every placement was like emotionally exhausting. I would find it hard to sleep you know when on placement. But now it's not so emotionally exhausting really because I know what I'm doing…so it's not the first time you are doing anything'.
>
> (StMid10/FG2/18 months)

One participant described how she felt she had changed since commencing the programme in terms of what she thought resilience meant to her and the significance of emotions:

> 'When I started the course, I don't know, something felt different, like completely changed really, It's really strange…and it's as though you have to be emotional to sympathise with other people's emotions and I've learnt it is not a weakness at all and you can actually show somebody how much you care and how compassionate you are by giving them an emotion or a response'.
>
> (StMid3/Int./8 months)

- **Sub theme 2b: Having passion, balance and the ability to compartmentalise**

On many occasions during the focus groups and the one-to-ones '*passion*' was required to be a resilient, successful midwife, as well as being competent. It was clear to the students that, as midwifery was a tough profession, passion was essential to know that it was the correct career for the individual:

> ‘As long as you keep the passion then it increases our ability to be resilient’.
>
> (StMid25/FG4/18 months)

> ‘I think you have to love what you do and really enjoy it because it is hard work, it is incredibly stressful, you have to have resilience to carry on even if you love it’.
>
> (StMid3/FG1/8 months)

> ‘You can see those midwives who don’t have that [passion] they do come across very hard and you see that from the woman’s point of view. I would much rather have someone who was showing a bit of emotion than not…I think it needs to be more acceptable to feel those emotions … it doesn’t make you weaker’.
>
> (StMid14/FG2/8 months)

The participants also felt it was important to be a balanced person in respect of their programme and private life. This balance enabled them to be able to take constructive criticism when they made mistakes and not take things personally. There was a lot of discussion about trying not to do anything wrong and what would happen if they made a mistake. They felt it was important for student midwives not to be too hard on themselves when they made mistakes or could not do everything. Personal insight was cited as a requirement to be able to cope when they felt they were being personally challenged. The participants expressed how they often experienced self-doubt in terms of their capability to complete the programme and become a qualified midwife.

The term ‘*balance’* described what was needed in both their personal and professional lives. The students described how they were ‘*strict’*

with themselves in terms of their approach to their programme work and meeting their deadlines. The term '*self-regulating'* was used to describe how they had to adapt both their personal and work life in order to keep up to date with the demands of the programme:

> 'I think it is important to be strict with yourself as well…it is very easy to get wrapped up in your studies especially when you are on placement…and then thinking, 'oh I should have gone to the gym' or 'I should of met my friends'…'.
>
> (StMid2/FG1/8 months)

The participants described midwifery practice as being very hard emotionally and it was very important to find a balance and personal self-regulation to be able to cope. The importance of having a life outside of midwifery was stressed by many of the participants in order to retain some perspective and balance:

> 'I think the moment you don't have that release outside work is the moment that then your profession is going to be jeopardised in your professional behaviour…it is a stressful job…you've got to be highly motivated to do everything that needs to be done on a labour ward and at a community setting there's so much pressure there, that you need down time'.
>
> (StMid25/FG4/8 months)

Students described how they found it hard not to think about what had been happening in clinical practice when they were on their days off. The word '*decompartmentalise*' was used to explain how they felt that the different aspects of their life needed to be kept separate:

> ‘It’s about trying to decompartmentalise things so you can still function, outside the wards, in your daily lives so that your emotions don’t cross so much so you can have at least a positive outlook in at least one part of your life….there are layers in what we do and if all those layers have got something that is not quite right then it can be a massive thing so if you can keep them slightly separate then you can deal with that…’.
>
> (StMid25/FG4/18 months)

A question was asked about the ‘*midwife’s hat’*; a term used to describe what a practitioner did emotionally as they started and when they completed a clinical shift (Nolan, 2014:22). The students agreed that they spent time going through clinical events once they had completed a shift. Some students described dreaming about the events they had experienced in clinical practice describing that they struggled to take the ‘*midwife’s hat*’ off.

> ‘I go to bed I am dreaming about being on shift like we had a fire alarm and I woke up and I’d thought …that’s the emergency buzzer’.
>
> (StMid4/FG2/8 months)

Nevertheless it was felt important to separate work and home life:

> ‘When you go home you are just you, not the midwife. I also have to look after me as a person and make time for other things in my life it’s not just midwifery… that’s part of my resilience learning how to have other things alongside it’.
>
> (StMid10/FG2/18 months)

> ‘I think it is about…compartmentalising your life. I think you can’t cope if you are being all things to everyone all the time. I think when you are at work you wear your uniform and part of that is your professionalism but for me that symbolises the midwife’s hat. I’ve got a role I am going to do this and that, I am here to work and impress everyone. I do my best and that is hard. And when I am at home I’m in jeans and trainers and I let my hair down and I can give myself a bit of a break and by doing that it’s quite clear the expectations of myself in each place…’.
>
> (StMid19/FG3/18 months)

However, the participants felt that going through what had happened, to make sense of it, was very important:

> ‘…my thing is when I drive home it’s sort of my time to clear my head’.
>
> (StMid21/FG2/8 months)

Additionally it felt that it was important to be able to concentrate on the good times they had experienced in midwifery practice during the bad times, in order to be able to process it and move on. The groups agreed on the importance of having a positive mental attitude, being able to ‘*pick yourself up’* and ‘*move forward’* was key after experiencing difficulties in midwifery practice:

> ‘I am a positive person…[and that] helps my resilience’.
>
> (StMid9/FG2/18months)

- **Sub theme 2c: Being flexible and adaptable**

Flexibility was another trait that was seen as important by the participants for student midwife resilience. The participants gave examples of how a student midwife needed to be flexible in their approach to be able to cope on the programme. The groups attributed the term '*adaptability*' to being able to be resilient as students negotiated different situations. The group additionally commented on how adaptability had been seen in the midwives they had been working with in clinical practice:

> 'Perhaps adaptability, to adapt as to well to challenging situations'.
>
> (StMid5/FG3/8 months)

> 'I think that's resilience when you go between different members of staff and you sort of have to adapt really quickly to their style and work to them and it's quite nerve racking actually working all day with someone who is a stranger and having to prove yourself and that shows resilience to be able to do that'.
>
> (StMid19/FG3/8 months)

The students also described how they were adapting to being a professional and what that entailed for themselves and their relationship with the woman and her family:

> 'I think it's the workload they have has forced them to be that way…and them adapting to different situations…they are sort of put in [to care for] one woman who is completely normal and then another woman that needs all the help in the world. And having to adapt to these situations and understanding of different people's needs…forced them to be resilient'.
>
> (StMid24/FG4/8 months)

Being a midwife was described as being very '*fluid*,' and lacked routine from day to day, which they felt some people would find difficult, particularly if they were someone who needed structure and routine. The students described the need to be able to cope with being '*out of their comfort zone'*. They were realistic that life in general, with its changes, often does not go down the planned path:

> '…if that was your kind of personality and you are going to be a midwife….if that was the structure that you wanted because it is very fluid isn't it? But that's what appeals to most of us I would imagine, that is very different, very variable but for some people that wouldn't be for them…'.
>
> (StMid16/FG3/8 months)

A unique term '*reactability'*, the ability to react quickly, was used by some of the participants to describe what they were doing to be able to cope with the programme and midwifery practice. One of the key issues appeared to be that within the midwifery programme there were many different components that brought about constant change:

> 'It's like your *reactability* isn't it, because you chop and change so much in what you do. You go into practice, then you have to be a student again, an academic student and then having to chop and change between the two'.
>
> (StMid3/FG1/8 months)

The groups described resilience as a changing feature that fluctuated on different days. They reported that they had developed strategies to '*leave at the door*' any issues that were on-going in their personal lives. Overall, however, the participants felt they had come a long way in terms of adapting during the first 18 months of the programme.

They were much clearer about recognising their own limitations and, unlike earlier in the programme, would not allow themselves to be put under too much pressure when in clinical practice. The group described how they were going through an identity transition, as they become the midwife they wanted to be. The importance of gaining knowledge in the underpinning theory for midwifery practice was key to their development as a student midwife.

Organisation seemed to be important to the participants to support being able to cope with the competing things they had to do on the midwifery programme. They recognised the importance of being '*on top of things'* in terms of the positive effect this had. They described how there were '*layers of things'* in what they did and dealing with them separately made it more achievable, particularly when there were lots of things happening at once. By being organised they were also '*keeping things in proportion*' and dealing with the problems as they arose and not letting them become bigger, which was important.

4.5.3 Theme 3: Opportunities to promote and threats to hinder resilience in a student midwife

The participants discussed a number of factors that influenced their resilience. The students demonstrated within the data many examples of how they were coping on the programme. For example, building up their confidence through practising the skills and theoretical study. There were several factors that appeared to promote and threaten their resilience, namely: reflection and reflexivity, approaches to the programme, the effect of clinical practice and the importance of self-care, and being a mature student.

- **Sub theme 3a: The reflexive student midwife**

The students described the importance of needing to make sense and deal with what happens in practice, challenging their assumptions and learning as a result. The student midwife as a reflexive practitioner was considered to be an essential requirement to be able to deal with problems:

> 'I think you can't be truly resilient if you have not truly digested what you are being resilient about…'.
>
> (StMid16/FG3/8 months)

> 'Maybe it's something to do with being able to rationalise what's going on…to be able to say rationally, if this is true what can I do to go forward [and] not being …affected'.
>
> (StMid19/FG3/18 months)

The groups agreed that they sometimes needed time to process what was going on, through a time of reflexivity, to challenge their assumptions, in order to deal with it. Reflection was described as an important attribute in order to be able to interpret and understand what was happening on the programme and to be able to learn how to approach the same situation should it arise in the future. How the participants reflected was different, for example, a quick reflection at the time of the incident would be followed up by considering the issue in more detail later. Other students described how they did not always feel written reflections necessarily helped them to deal with how they were feeling emotionally and that thinking through things was just as effective.

The term '*closure*' was also used to describe what needed to occur once they had reflected and made sense of what had happened; this was often done in the company of others:

> 'And a debrief… we went for a coffee a couple of times didn't we and that was really helpful'.
>
> (StMid1/FG2/8 months)

> 'My last shift on labour suite I was in with a shoulder dystocia and the baby died…and I was dreading going back…I … just had to sit and [think about] what… actually happened, how am I meant to feel about it, I don't know how I'm meant to feel about it…'.
>
> (StMid24/FG4/8 months)

They felt that constructive reflection assisted them in gaining perspective on and understanding of the situations they were experiencing in midwifery practice. One example of how to constructively reflect was the use of a daily journal. The participants felt it was important to allow some distance from the incident in order to reflect effectively:

> 'That's why I think my journal, writing a journal was quite good because whenever I get back from my shift I write just a couple of pages…so I've told someone else rather than my brain. Then I can go to sleep and I don't have to play it over in my head'.
>
> (StMid16/FG3/8 months)

> 'Sometimes I think reflecting straight away after something has just happened if there has been a bad experience, it is going to be negative if you are just processing then you can move on from [it] and the next day talk about it again'.
>
> (StMid10/FG3/8 months)

The students agreed that it was important to reflect on the good things as well as the bad things to maintain that positive attitude that is needed to be resilient; this included giving themselves praise when there had been an achievement or getting positive feedback. Nevertheless, there were other factors that affected the resilience of the student midwives.

- **Sub theme 3b: Approaches to the programme**

There was a lot of discussion on how the programme's workload was managed and objectives achieved alongside other competing demands. The analogy of building a tower with blocks and its fragility was used to illustrate how they were coping with all that was placed upon them:

> 'It's almost like…playing with building blocks you think you're building up this tower, you are building it up and then a little bit falls off so it's ok we'll pick that back up and we will put it on again and then you get a bit higher and another few more bricks fall off and that all makes a few more fall off and I think it's how, it's how you pick yourself up…if you are passionate about something enough, then your resilience will keep propelling you forward to make sure you get to your end goal. Those building blocks aren't necessarily children and all the rest of it, those building blocks are your life and it's up to you how you want to arrange them…into a new life'.
>
> (StMid25/FG4/8 months)

The groups described the programme as being very tough. They stated that this would prepare them to be the '*best*' midwives stating that it was giving them the opportunity to develop their resilience for the hard job to come:

> ‘Because the job is not easy if you had an easy training then to do a hard job you wouldn’t have that resilience kind of trained into you’.
>
> (StMid19/FG3/8 months)

Time was discussed a lot in the focus groups and seemed a key consideration as the students described feeling ‘*time pressured*’ and felt they needed to organise their time meticulously in order to meet the demands of the programme. Participants suggested the essential activities for resilience were to accept the high workload in midwifery and adopt a variety of organisational strategies:

> ‘I think learning to accept that you just get on with it; that I didn’t realise until recently’.
>
> (StMid8/FG4/18 months)

The groups described that there was *‘no let up’* on the programme. Also the clinical environment was described as ‘*hard*’ and very busy, which was exacerbated with staff shortages. This made it difficult to be resilient at times. Interestingly, the participants felt that it was the simple things that could ‘*push people over the edge’* for example, off duty and challenging mentorship.

Not all participants felt that the workload was insurmountable:

> ‘I think the way the course is planned out helps you to be resilient because you are at university and you’ve got whatever exam or assignment and you just kind of focus on that and then once you are on placement you know you’ve got something else to focus on. So it helps you to get through more easily’.
>
> (StMid7/FG2/8 months)

Keeping a focus on the task in hand was seen as being needed to be able to keep going despite adversity in the programme:

> 'Being proactive as well. It's not that you don't get upset about some things but it is the way you move forward'.
>
> (StMid10/FG3/8 months)

Not being easily offended and being able to take constructive criticism was seen as an important trait by the participants for all areas of the programme, both in theory and practice. However, being able to take constructive criticism involved developing the skills of standing up for oneself, to avoid getting stressed or panicked, and this was also key. When the focus groups met for the second time the groups gave examples of a number of instances when they had experienced low points in the programme but had moved on and overcome the challenges they had been facing. They felt that they were developing and changing whilst being on the midwifery programme and that they were building as a person.

When the focus groups were repeated, 18 months into the programme, the participants' discussions revealed that they had a clear sense of what was expected of them in the second year of the programme and this assisted their resilience. As a result of being better informed about midwifery theoretical concepts and their practical skills developing, the participants felt that they were more resilient. They shared a lot of examples of stressful situations in midwifery practice that they were now able to deal with. They were clear in their discussion that it was not helpful to dwell on things when they went wrong. They also felt that '*seeing the bigger pictur*e', i.e. qualifying and becoming a registered midwife, was needed so that things did not get out of proportion.

There was insight into how they recognised that the programme was challenging them but it was necessary to become a safe and competent midwife, nevertheless, at times they felt very overwhelmed:

> 'I wonder if in the future as a cohort we will make better midwives because we've had more challenges…I think we will. I think it will be harder now but in the future it will be beneficial'.
>
> (StMid20/FG3/18 months)

> 'Again it's that perspective on resilience. It is tough now but I will get through it and it won't always be this way'.
>
> (StMid19/FG3/18 months)

- **Sub theme 3c: The effect of clinical practice and the importance of self-care**

The reality of practice was described and the effect this had on the students. Midwifery was seen to redefine the individual student midwife as they progressed through the programme; this included examples when they had been involved in challenging situations including fetal loss:

> 'You feel like you are not really prepared and yet if we got more preparation for practice would it do us any good? I'm not sure if it would because you have to go and experience it don't you?'.
>
> (StMid3/FG1/8 months)

The group discussed that there was a need to have a realistic vision about what midwifery is about and not give up at the first hurdle, as there were many challenges to face. They recognised that they would experience good and bad times in midwifery practice so a balance was struck. Nevertheless they felt proud to be part of something, i.e.

becoming a midwife. They felt they needed to learn to '*roll with the punches'* and accept that what happens cannot be prevented from happening:

> '…all midwives have their own values and you can tell in their practice but I don't think it matters that everyone is slightly different because even if you have got the *'midwife's hat'* on you are still you, your personality…some midwives their personality disappears…'.
>
> (StMid5/FG1/18 months)

They described that by 18 months into the programme, their confidence was developing and they were more willing in practice '*to have a go'* and take the initiative by leading care under the supervision of their mentor, which was helping them to develop their own ideas. There were a number of examples given where the students were witnessing situations in practice that conflicted with what they had learnt theoretically and what they believed in philosophically. The students described feeling very uncomfortable with how some mentors practised and did not like their interventionist approach to midwifery care:

> 'Sometimes I think it is like I am holding my tongue…because the Trust that I am in how it's much more medicalised than my home Trust which really, really annoys me but obviously in front of the women and everyone you can't say that…I'm just trying to be calm in the situation as calm as I can…'.
>
> (StMid8/FG4/18 months)

By 18 months into the programme and with more theoretical knowledge they felt better able to challenge decisions in relation to

the care of the women. Additionally, they felt more equipped to negotiate individual mentor's expectations.

It seemed important to the participants that it was recognised that everyone was an individual and adopted different strategies to cope with midwifery practice. There was clear agreement across all the participants that resilience was demonstrated by '*dealing'* with the problem or challenge. Dealing with the problem was described in several ways but included seeking help and discussing the situation to make sense of what had happened:

> '…everyone is different in how [or] you should do that. It's quite difficult, as I say everyone deals with it quite differently. Some people need to be on their own, some people need to talk … Oh [it] definitely needs to be coped with…. But it's facing it isn't it, it's knowing…pushing it down'.
>
> (StMid21/FG2/8 months)

> 'I had a mentor that had quite a bad outcome in the community…and it had affected her a lot, so people said to her why don't you…would you like to change areas…but she said 'no I don't want it to affect them in that way, I want to learn from it, I don't want it to be negative'. So she carried on, so that was good she … tackled it head on …She said I'm going to stay here and … deal with it, deal with my feelings about it…'.
>
> (StMid1/FG2/8 months)

It was felt there was often a lack of control in what occurred in clinical practice and this challenged a student midwife's resilience:

'…and you become more resilient because of situations you have seen and been through…you kind of keep going up the levels and you reach the point where you are at the highest level of resilience you can possibly be because you've experienced so much and seen so much and learnt from it'.

(StMid25/FG4/8 months)

'Some days you may feel more resilient than others as you are more emotionally stable…but then we all have capacity to leave it at the door…so I think being able to control that emotion while you are in a professional position is resilience. But you need time away to let it out, to go with what your emotions tell you to do'.

(StMid14/FG2/18 months)

The clinical placement area seemed to be a place where the students had a keen sense of '*being under scrutiny'* and judged all the time, as well as having to impress mentors who were going to ultimately assess them, trying to please the mentors and not do anything wrong. This was described as causing the students a lot of pressure and they felt that throughout the programme they were personally tested:

'…you are going to make mistakes and you really get some really supportive person who says you did make that mistake or maybe you didn't handle it in the right way...but then some people will say you've absolutely done that wrong and that person who is on the receiving end that may not be constructive criticism then being able to…to not let that devastate them'.

(StMid3/FG1/8 months)

'You're under scrutiny all the time, you really are'.

(StMid15/FG1/8 months)

However, they used analogies to represent how they were feeling as they progressed on the programme and the reality of student midwife practice:

> 'We use the analogy of the duck on the water…their feet under the water are going really crazy and yet they are gliding along'.
>
> (StMid5/FG3/8 months)

They talked frankly about the challenges they faced during the programme, particularly in the placement areas, and the role that resilience played. The students felt that uncertainty and '*not knowing'* seemed to exacerbate their reaction to problems:

> 'I think there is a scale of coping. I think the way I understand resilience is an ability to cope and I think it is tested by your circumstances. How hard your life is around you forces you to be resilient or actually not give you the opportunity to demonstrate that'.
>
> (StMid19/Int./18 months)

> '…I find one of the hardest things is being professional especially when I am really tired and then I get hard on myself…'.
>
> (StMid8/FG4/8 months)

> '…there was a situation where…the father and her mum [were] getting so stressed and angry at us…they were sort of shouting…and I just think if someone from the outside world was speaking to me like that I may have acted very differently but in that hospital setting it was very much trying to calm them down…'.
>
> (StMid24/FG4/8 months)

They reported having experienced new things on the programme but admitted that they had doubted their abilities along the way. One student shared not even liking what she had initially experienced on the delivery suite and found women in labour quite upsetting. Student midwife practice was said to define both student life in theory and practice.

They had also witnessed situations where there had been poor outcomes for women and babies that had been challenging for them personally. However, the participants were clear that they needed to accept situations and they did not want to be affected by it. The students were clear that they wanted to learn from the experiences using reflection and dealing with the strong feelings they were experiencing:

> 'Maybe if someone wasn't as accepting of the facts and then dealing with them'.
>
> (StMid7/FG2/8 months)

The students found working in the clinical area hard, physically demanding and that it made them very tired. The participants described the effects of working full time in clinical practice, which often demanded working very long shifts, 12 hours in length. The switching between attending theory in the university and the practice shifts was also said to be particularly challenging.

The participants recognised that they needed to look after themselves physically to be resilient:

> 'I think the times I've had problems with resilience…when I started to doubt whether I am in the right career…it's not even just the tiredness, hunger or like stress…if it's exactly the right thing for you then it's absolutely worth it'.
>
> (StMid8/FG4/8 months)

The effect of some physical factors that had significance on their resilience was discussed, including the importance of looking after themselves:

> 'I think physical barriers for me. I am less resilient when I'm hungry or tired or ill. I think you need to be well and healthy physically and then I think that gives you strength for you to cope. Or actually like external circumstances, it is very difficult to be resilient in every area of your life, if every area is challenging'.
>
> (StMid19/FG3/8 months)

Examples were given of other factors that were affecting student midwives' resilience. They described how some students in their cohort were experiencing difficulties in their personal life; resilience played a role in supporting them to get through:

> 'Because you can meet people who have been through everything they can be through and they've had a really hard time but they would still say they aren't resilient even though they have to have some resilience to have been through so much'.
>
> (StMid16/FG3/18 months)

Many of the examples that the focus group participants used described the clinical placements that the students had undertaken. The students reported finding the relentless nature of the programme, particularly the demands of being in theory and then working full time in clinical practice. This was particularly felt after they had sat an examination in the university:

> ‘I’m sure it was the Friday and then I was back on placement on the Monday and it was like…you’d just had so much on…I would have just appreciated two extra days off you know just to be able to relax’.
>
> (StMid6/FG4/18 months)

The students had witnessed staff shortages in the clinical areas and the effect it was having on the midwives they were working with. The focus group participants gave very candid examples of what was happening to them in practice and the effect this had on them personally. The clinical areas were described as being very stressful where midwives were subjected to a lot of pressure. They had witnessed some very upsetting events early on in their student midwife journey. The participants reported how vulnerable they felt in practice, particularly when they were not clear about what was happening. This also seemed to be reducing as they progressed through the programme.

It was key to the participants that a student midwife was able to adapt to what was going on and not let problems affect them unduly. The participants stated they were conscious of the importance of not letting themselves become stressed as a result of what was happening in the clinical area:

> ‘I think it comes down to recognising again really how much of an effect it has and...how you can handle [it] just by talking to somebody at work or whatever, letting somebody know what’s going on or is it going to have too much of an effect… You can’t let it overly stress you’.
>
> (StMid2/FG1/8 months)

- **Sub theme 3d: The mature student midwife**

Seven of the participants were defined, for the purpose of this study, as mature students, namely 25 years or older; these students were graduates or coming into midwifery as a second career. In comparison to the students who commenced midwifery in their late teens, straight from school or college, they seemed to be experiencing particular challenges in adjusting to being a student midwife and the competing demands placed on them:

> 'I've really struggled with life and balance and that's hit me and I've had loads of meltdowns so I don't know whether it's like mature students it hits or it's a big shock coming to university…'.
>
> (StMid11/FG4/8 months)

One mature student in the group, however, did not feel her life had changed since coming onto the programme. She felt her life was just the same and implied she was naturally resilient and did not need to do anything or put anything particular into place, for example: '*same friends'*, '*same family' 'everything the same'*. The other participants did not respond to this contribution and it was noted that this seemed to be her personal viewpoint that did not appear to resonate with the rest of the participants of the focus group. Another mature student shared some of the specific challenges she had faced since coming onto the programme and the role resilience was playing:

> 'I think you can learn to be more resilient. I think we have all changed and developed as student midwives even in this short time…I think on this course you learn resilience, you mature very, very quickly…I thought I had done all my growing in my adult life but actually no…if you didn't have that passion you wouldn't want to juggle all those balls…'.
>
> (StMid25/FG4/8 months)

When the participants took part in a focus group, on the second occasions they had undertaken non-midwifery placements and were in their '*away*' trust. There were mixed views about the non-midwifery placements, which some participants had found particularly challenging:

> 'I had to find a way, I had to find a way to get through that time I was not particularly enjoying much by having a focus, by having something to look forward to. I think definitely resilience had a massive part to play…'.
>
> (StMid25/FG4/18 months)

4.5.4 Theme 4: Reliance and relationships with others

The groups felt it was very important to interact with others and not keep themselves isolated. The participants described the importance of others to help them through the midwifery programme. The focus groups also felt that it was important to recognise what was happening to them such as feeling upset or sad and knowing when to seek support and help. They agreed that asking for help was not a sign of weakness but it was key to learn to control their emotions until an appropriate moment:

> 'You've got to be honest with yourself as well. You've got to be someone who is accepting of it right now and do something about it'.
>
> (StMid20/FG3/8 months)

Participants shared a range of difficult occurrences in their personal lives since commencing on the course e.g. divorce, separation and illness of family members:

> ‘The course does not leave you much room for anything else to go wrong’.
>
> (StMid2/FG1/18 months)

There were many examples given of the effects of current personal circumstances and the impact these were having on them as individuals. The participants agreed that resilience was demonstrated when an individual dealt with a situation and recognised when they were not fit to be in practice. Support was seen as very important during the midwifery programme, when they needed it, and their mentors and personal tutor were cited as key players:

> ‘I found on my first day we had an emergency and it was all really overwhelming…and then afterwards my mentor was like really good and she talked through it all with me so it kind of gave me like a good example of how to be resilient in that situation. She was like “how did that feel when this happened?’.
>
> (StMid10/FG3/8 months)

> ‘In my community team I would say I found it quite difficult to be resilient at first because they were dealing with like shortages of staff…it was a very stressful environment a lot of the time. There was a lot of moaning, my mentor was extremely twitchy all the time…’.
>
> (StMid10/FG3/8 months)

The participants discussed their mentors at length and the effect they had on their experience and confidence:

> ‘I couldn’t imagine what I would deem as a bad mentor. I couldn’t imagine how I would cope with that because I’ve had such great support so far and I felt like they entrusted me a lot and put a lot of faith in me and built my confidence up and say you can do it and you’ve done really well’.
>
> (StMid3/FG1/8 months)

The groups, at eight months into the programme, seemed to display maturity in terms of how they were dealing with situations in practice including how they worked with midwifery mentors who they saw as ‘*difficult*’. They described how they identified with being a midwife and the impact of experiencing working with a range of different mentors. Nevertheless, they specifically commented how the course structure was helping them to succeed, as it was not ‘*tripping you up’*. For example, not having theoretical assessments to complete when they were on placement enabled them to concentrate on achieving their practical competencies.

They described that there was variability in the mentors and their approach to students and what effect this had. For example, some were very negative about the NHS and questioned what the student’s motivation was to be a midwife in the current climate. They described the importance of having good relationships with mentors:

> ‘…really took it home thinking that midwife thought I was really stupid, that midwife thought I was useless…ok she was really busy and said it that kind of way, well I’m a first year and I’ve got a lot to learn’.
>
> (StMid3/Int./8 months)

When the focus groups met for the second time the participants recalled how their approach had matured for example, in terms of handling difficult mentorship:

> 'She openly said to me that she had been described as very harsh…a bit overpowering sort of person so I worked with her for a week and absolutely hated it and nearly thought "I can't do this job, I'm no good at it" then swapping mentor so realising it was not me…I'm back with that mentor and I thought initially I'm going to ring up and swap that mentor and then I thought no I need to work with that mentor and try and put the positives on it…and try and learn from it…'.
>
> (StMid13/FG1/18 months)

> '…the mentors that normally have students know how to deal with students…so everyone really has had good experiences'.
>
> (StMid17/FG1/8 months)

Whilst mentors were seen as key to supporting them on their programme, the group also described the effect of mentors who seemed disillusioned with midwifery and spent time moaning in front of the students:

> '…just a lot of complaining about the management and stuff…which is actually annoying but it's like a tiny part, tiny part of the job and that's the unfortunate thing like 80% is about the women and I think they have lost that…I felt like they were there just to do a job, to pay the bills rather than because they wanted to be a midwife'.
>
> (StMid8/FG4/18 months)

> ‘I do feel there is a culture of moaning though, everyone these days everyone moans all the time…when I am qualified I am determined not to let myself get like that because I think why don’t you just come to work and when you are at work enjoy it while you are here…but it’s not quite like that is it?’
>
> (StMid6/FG4/18 months)

> It’s quite nerve racking actually working all day with someone who is a stranger and having to prove yourself and that shows resilience to be able to do that’.
>
> (StMid19/FG3/8 months)

The students gave many examples of the different styles of mentorship they had experienced and the effect this had on them:

> ‘I had two mentors that were completely different and one of them everyone was like saying ‘oh she’s really scary’…but actually different style of working has definitely made me work in a better way’.
>
> (StMid16/FG3/8 months)

Repeatedly the students talked about the need to get things right and to avoid making mistakes:

> ‘I think we should be allowed to get things wrong…I’ve worked with so many different mentors especially on labour suite and some of them sort of like they expect you to be able to do it…’
>
> (StMid20/FG3/8 months)

The significance of having a positive relationship with clinical mentors was repeatedly discussed as they were seen as key players in the success of the student:

> '…I just didn't get on very well for the first two weeks and I think it's the first time that I had not clicked straightaway with my mentor and I did not have that in my first year. Every single mentor and I got on really well or they were really helpful. But for the first two weeks it just made me think. What am I doing? What am I doing here? There's no point but obviously you just have to push through. I think that's resilience because you know some people do not have the same outlook as you…you just have to push on'.
>
> (StMid24/FG4/18 months)

They described being acutely aware that they had to prove themselves to their midwifery mentors. Examples were given of how sometimes they pretended to be '*confident*' in front of their mentors. Nevertheless, they felt that they were '*growing*' in midwifery by being tested.

Another significant effect on the students was a mentor's criticism. When the students met later in the programme they shared that they had come to the conclusion that they did not '*always need to be perfect*.' Nevertheless, they were very conscious that the mentors would be ultimately be grading their practice and the influence this would have on their module marks:

> 'I think it's knowing yourself as well because if someone criticises you then unfairly… you could think it was true…if you know yourself and you know you are better than that then you think 'no I don't agree with that'. It's accepting what you think is fair'.
>
> (StMid3/FG3/18 months)

> '…the fact they grade us they mark us you have to impress…even though you don't agree with them. Some mentors don't like to be challenged…it's all great maybe for the woman's care…but for me personally…'.
>
> (StMid20/FG3/18 months)

The students described being affected adversely by the members of their group who had left the programme due to academic failure. The participants expressed a different reaction when considering students who had left the programme for reasons other than academic; for example:

> 'I think if you love midwifery enough then that's the main thing…I think people who've left the course left because they don't love midwifery enough, that's their main problem'.
>
> (StMid8/FG4/8 months)

The students commented on the importance of being able to recognise when they needed to take additional steps to be able to cope with what was happening in midwifery practice and their personal lives:

> 'Admitting when you need the extra help as well. Recognising your own signs and symptoms…then being able to access the extra help that maybe is needed…and just taking the some time to do, to be yourself and maybe re-group your thoughts…'.
>
> (StMid25/FG4/18 months)

The group was in agreement about the importance of significant others such as husbands, partners, family members and friends, in giving them support whilst they were on the midwifery programme. The participants recognised the need to be supportive of each other,

particularly as they were experiencing similar difficult situations in practice. One student described how her mentor was coping with her father being very ill:

> '…and it is a big thing for a parent to be ill and to be able to go to work and completely forget about it and look after the women. I think that showed a lot of resilience'.
>
> (StMid16/FG3/18 months)

The groups gave many examples of how family and friends were supporting them throughout the programme. Nevertheless, having someone to bounce ideas off was very useful; they were aware that they often had to deal with things on their own. Friendship groups were seen as particularly important as they could empathise with each other in respect of what they were going through.

The participants spoke about sometimes needing to speak to someone who had no experience of midwifery to avoid burdening their personal tutor or friendship group. However, they also recognised the importance of maintaining confidentiality. Additionally the participants spoke about needing to be realistic from the beginning about what the programme was going to be like and that new support mechanisms needed to be developed:

> 'I've spoken to some girls on the course that are away from home…and they haven't particularly enjoyed it as much as perhaps others who do have family nearby and do have peer support and have made good friendships within the group. I think that can be a barrier'.
>
> (StMid9/FG4/8 months)

The participants additionally described the importance of looking after themselves. They had found it particularly challenging when peers had left the programme and felt it had been a mistake to rely so much on them as once gone this had negatively affected them:

> 'When you have friends on the course and you have lost that support I found that had a massive impact'.
>
> (StMid4/FG2/18 months)

Another key person that students relied upon was their personal tutor and the support they gave was key to the students feeling supported on the programme:

> '…I have a fantastic personal tutor but I feel like some people have never spoken to their personal tutor and actually that really limits your escalation, it limits where you find your support, I know if I emailed my personal tutor, both personal tutors, [to say] I am having a crisis they would…ring me that day you know and that is valuable when you need it'.
>
> (StMid16/FG3/18 months)

However, not all experiences were positive about their personal tutor and the support they offered:

> '…I am not surprised that people feel like that because I've had that experience so you know every time I've asked for help I've never had any help and now I don't ask for help again'.
>
> (StMid3FG3/18 months)

A number of personal strategies were described to be able to cope with the demands of the programme. Support appeared to be a key

strategy when they had experienced challenges or difficult situations and this helped to boost their confidence.

4.5.5 Theme 5: Resilience, the student midwife and childbearing women

The role resilience played in the relation of a student midwife with childbearing women was discussed across all the groups. The groups were mindful that it was important to support women without becoming '*hardened*'. Demonstrating their passion for midwifery practice and being reflexive was key in this. The participants felt that they needed to be resilient for the women in their care. The students also described how they were adapting to being a professional and what that entailed for themselves and their relationship with the woman and her family. The process of labour was seen to potentially affect a woman's vulnerability and the role of the midwife in supporting them was described as being crucial. They additionally thought that a midwife being calm and compassionate when caring for a woman resulted in '*building*' as one unit. This allowed the woman '*not to cope*'; however, the role of the midwife was to encourage her resilience by positive statements such as '*You can do it, you can do it*'. The student midwife's resilience seemed to be enhanced as their confidence in supporting the women developed:

> '…I think [a midwife] shouldn't appear resilient, I think it should be so kinda natural, I think if you come and you're struggling and you're appearing resilient to the woman, they see you are coping with the struggle…'.
>
> (StMid19/FG3/8 months)

> 'I think it [resilience] rubs off on them [the women] without us realising it'.
>
> (StMid20/FG3/8 months)

'…our resilience allows them to be weak to some extent … there are certain things that the woman can't do, struggles to do, and I will do it for her, allowing her not to cope in that situation…'.

(StMid19/FG3/8 months)

However, they felt that it was important that women were able to see emotional responses in midwives, which demonstrated to them that those caring for them had care and compassion. The groups agreed that women should see their human side whilst remaining calm in demanding situations:

'….she kept so calm and I think that was important for the woman'.

(StMid6/FG4/8 months)

'I think you can feed off resilience can't you? If you've got a resilient midwife who is obviously confident, is able to cope with the situations…able to control their own emotions and be able to act to what needs to happen, that kind of *'feeds'* the woman…if you've got a sort of air about you…you're confident… It would help to earn their trust because I think with resilience comes confidence and I think that could then influence how a woman is in a room or could enhance the relationship that is able to be built up between the mother and the midwife…to show emotions shows the woman and families you are human'.

(StMid25/FG4/8 months)

Nevertheless, they felt that resilience was not visual to anyone else, stating it was a natural trait and the women would not be aware of this in a midwife. The group felt that they needed to be resilient to

effectively support the women in their care, to help them be stronger. They expanded on this by stating that a midwife needed to use their strength to make the women strong. They described that the trait of resilience had to be developed to be successful as a midwife and confidence would follow as a result:

> 'You don't see resilience. I would never describe someone as 'Oh she's so resilient''.
>
> (StMid13/FG3/8 months)

> '…I think if you help them to be resilient yourself if you are calm and relaxed and sort of talk them through…help them understand they are doing really well'.
>
> (StMid20/FG3/8 months)

4.6 A comparison of the True Resilience Scale© scores and the focus groups

A sample of individual participant's True Resilience Scale© scores from across each focus group were reviewed in relation to how they discussed resilience within their respective focus group, across the eight and 18-month time periods (see table 11). The participants' True Resilience Scale© scores that had increased, decreased and remained the same were reviewed. In the focus groups, which had an increased or a static resilience score, there were examples of discussing their resilience as having increased. In contrast, in the focus groups that reflected total resilience scores that decreased between eight and 18 months, this was not reflected in the focus group conversation.

Focus Group no.	8 months	18 months	Comment
1	126	133	1 student left programme. 2 students joined from another FG for 2nd session
2	133	121	1 student from another FG for 2nd session
3	123	123	1 student left programme
4	118	118	

Table 11: Average True Resilience Scale© scores by focus group and timescale of programme

The sample of students was mixed in terms of their resilience scores and how they described resilience and their own experiences (see table 12). The student whose score increased the most offered some clear insight into their own resilience. However, two students whose scores had decreased between eight months and 18 months on the programme did not reflect this in their contributions in the focus groups. The student who had the lowest True Resilience Scale© score overall did not contribute in the focus group at 18 months. In a follow-up one-to-one interview this student recounted very clearly why their resilience was low at that time on the programme.

St/Mid no.	FG	TRS score 8 months	TRS score 18 months	Trend	Comment
St/Mid 2	1	131	131	↔	Knew how she could manage herself Welcomed constructive feedback
St/Mid 17	1	119	127	↑	Welcomed feedback Described she could get over things promptly 18/12 needed to work hard, not an ordinary student Took feedback to better oneself
St/Mid 5	3 &2	115	140	↑	Insightful about resilience Need to move forward following experiences Need to deal with stressful situations Have to understand how you are feelings, know your limits 18/12 Being a student midwife is not the whole of her life
St/Mid 12	4	111	88	↓	8/12 Referred to resilience in the 3rd person 18/12 Little contribution in the focus group
St/Mid 6	4	131	119	↓	18/12 Though was a lot more resilient now. Being more organised has made a difference Will remind oneself why you are becoming a midwife even after a bad day
St/Mid 4	2	129	103	↓	8/12 Expressed self doubt. Affected by things she was experiencing 18/12 Had been affected by other students leaving the programme, stated she was now more resilient

Table 12: Sample of participants comparing the True Resilience Scale© scores and comments made in the focus groups

Key: 8/12 = eight months into the programme 18/12= 18 months into the programme

4.7 Conclusion

In this study the majority of students showed that their resilience had increased over the first half of the midwifery programme. Their increase in resilience was demonstrated through the completion of the True Resilience Scale© on three occasions and how they reported resilience during the focus groups and the one-to-one interviews. It appeared that the True Resilience Scale© scores and comments in the

focus groups were more consistent in the students whose scores increased than those whose scores decreased between eight months and 18 months on the programme.

The participants clearly articulated what the concept of resilience meant to them as student midwives and agreed it was needed for their longevity as midwives. They used the term resilience as being essential for student midwives to be able to deal with a range of stressful situations, in order to '*bounce back*' and '*move forward'* on the programme. The members of the focus groups all agreed that they were individually responsible for their own resilience and that a student midwife needed to be proactive in their approach to the programme, as well as have an optimistic demeanour to ensure resilience was maintained.

The participants described the characteristics of a resilient student midwife in detail and emotional intelligence and personality were cited as key features. Maintaining resilience when their self-esteem or confidence was low was thought to be hard.

The students in this cohort were all passionate about being midwives but they recognised that it was important to gain a '*balance'* between their professional and personal lives; this was achieved by '*compartmentalising*' the different parts of their lives and keeping them separate. The study cohort was clear that the midwifery programme was challenging but felt what was happening in their personal lives could not be underestimated and had an effect on their resilience. The '*midwife's hat'* was felt, by the participants, to be a useful concept.

Resilience was described as being a changing feature within an individual, which fluctuated at different times. As midwifery was a

profession that lacked day-to-day routine, it was important for a midwife to be flexible in their approach to practice. The student midwives in this study used the term '*reactability*' to describe the need to adapt and cope with the challenges that they came across in the programme and in clinical practice.

Participants were clear that resilience could not be taught; it had to be tested through experience and built upon. Being a '*reflexive*' student midwife enabled them to make sense of what happened to them in midwifery practice, which could be used to cope with the same situation in the future. On the second occasion that the focus groups met, they reported how their midwifery practice had changed between the first and second year and the importance that resilience played in this.

There were a number of factors, which seemed to both enhance and threaten the students' resilience and they described what they were doing to be resilient. For example, they described what they did to look after themselves, both physically and emotionally, which supported their resilience and their ability to cope with the demanding clinical environment. The importance of significant others, particularly mentors in practice, were key to supporting their resilience. The mature students, over 25 years of age, described the particular challenges they faced to promote their resilience.

The students described the importance of needing to '*belong*' in clinical practice and their mentors were key to this. Despite the challenges they encountered on the programme, particularly moving Trusts, they considered they would become better midwives as a result. They gave examples of being more assertive and did not try to please mentors so much. Outside of midwifery they also felt people saw them differently and viewed them as being a professional.

Of particular interest was how this cohort of students described the importance of resilience for the women in their care. They felt that their resilience had a positive impact on how a woman coped with childbirth. Additionally, the woman perceiving emotional responses in the midwife was found to be key to being able to build a positive caring relationship.

In conclusion, no participant had doubts about being on the programme. They expressed commitment to midwifery as a career and were passionate about becoming a midwife. Resilience was a concept that they could describe in detail and apply to being a student midwife.

Chapter 5.0 Discussion

5.1 Introduction

The concept of resilience is portrayed in the literature as being essential for midwifery practice (Hunter and Warren, 2014). However, to date no research studies have been identified which have explored the role that resilience might play in student midwives. The purpose of this study was to explore the concept of resilience with student midwives to establish whether there are specific considerations for this profession which could be used to enhance the understanding of the part it plays in the midwifery context. The study was designed to investigate whether or not resilience developed in student midwives over the first 18 months of their undergraduate programme, as well as exploring what the participants understood about the concept.

This chapter illustrates how the research questions were addressed, and then discusses the findings of the study. Drawing on relevant current literature, the discussion is presented under two overarching themes, specifically: defining resilience for student midwives; the development of resilience in student midwives (the True Resilience Scale ©, biographical profile, academic success and age; professional identity and philosophy; reflection and reflexivity, relationships with significant others and reactivity). A model of resilience for student midwives is offered for consideration by those developing midwifery education programmes.

5.2 Defining resilience for student midwives

The word '*resilience*' is in frequent use in everyday language, and its definition seems to vary depending on the context or the specific individual or group of people. The participants in this study agreed that the lay meaning of the term resilience was unhelpful to them and

a specific definition for student midwives was required. The participants suggested that the term resilience implied that they had to be hard and not be affected by challenges. The student midwives related many examples of how they were being impacted upon by the very challenging situations they encountered every day in midwifery practice. The student midwives in this study used positive words to describe their responses such as being able to '*deal'* with situations, '*bouncing back'* and being able to '*carry on'* as a midwife even following difficult situations. These in turn could be argued as ways to promote longevity in a midwifery career and the ability to be an effective midwife. Garcia-Dia et al's (2013:267) integrated review used such terms whereby resilience was described as the ability to '*bounce back'* following adversity with a range of factors affecting resilience, including environmental.

This student cohort was apparently relating that they were conscious of a range of active developmental processes that were occurring to them as they became a midwife. However, the strong negative words used by the participants clearly demonstrated the difficulties and challenges they faced on their programme. Masten's (2001:228) review of resilience definitions aligns with this study's findings in terms of the participants experiencing current or past hazards and that resilience developed as a result. Of interest is that Masten (2001: 228) discussed the development of resilience as being an '*ordinary process'* which this study's findings suggested is key during the preparation to become a midwife.

The participants in this study were clear that resilience varied over time and was affected by what was happening in their personal lives. They also recognised that their resilience did fluctuate between contexts. For example, being resilient in one place, such as their home life, did not necessarily mean this translated into their midwifery

practice. A similar discussion can be found within the literature when exploring whether resilience is a trait or a process (McGowan and Murray, 2016) and whether it is constant, either in time or context (Reyes et al, 2015).

The changeability of the trait could be problematic for an individual if they are low in resilience at a point in time and adversity occurs. Resilience was also described in this study as being variable, depending on the context. It was found to be needed in some situations more than in others and although the participants recognised some supportive educational activities may be helpful, promoting self-care, which included physical activity and encouraging acceptance of change, were also important considerations. Rutter (2006) recognised the effect of environmental factors and that physical and psychological changes affect an individual's coping strategies. The challenge, however, is to identify what the risks are to an individual's resilience and Rutter (2006) supported future research in individual differences of comparable experiences, rather than exploring resilience in general.

Reyes et al (2015) found that students demonstrated resilience by showing perseverance when faced with challenges and were both hopeful and optimistic. This study's findings reflected the strong ambition to become a midwife despite the challenges and perseverance was demonstrated in how the participants discussed their views and experiences.

Repeatedly the focus in the literature seems to be placed on the individual learning how to cope rather than the root cause of stress being addressed because the current workplace is socially, economically and culturally challenging (Cope et al, 2016; Crowther et al, 2016; Reyes et al, 2015). In the findings of this study the rhetoric

of midwives needing to be resilient was being used to mask a potentially bullying culture in maternity services. Arguably this narrative could perpetuate poor practice rather than dealing with the root cause.

Interestingly, more recent literature seems to widen the definition of resilience to include traits that are required to cope with the hostile clinical environment (Cope et al, 2016; Crowther et al, 2016; Reyes et al, 2015). Therefore, it could be argued that the expectation that the individual must be able to cope may condone current poor working practices and ignores where the responsibility to address hostile environments should lie. NHS employers should take a candid look at their workplace and take positive steps to enhance working conditions which value and support staff and, in turn, would improve retention. Signing up to the RCM's (2016) *'Caring for you campaign'* would demonstrate a commitment to valuing staff and improving working practices.

It is suggested that emotional resilience is needed to help healthcare professionals adapt to working conditions that are stressful (MacDonald et al, 2012; Stephens, 2013). In this study the participants felt that they had emotionally been on a '*roller coaster*' of a journey but, nevertheless, they had grown emotionally as the course progressed. Emotional intelligence has been identified as key to resilience, supporting and improving psychological well-being. Additionally, emotional intelligence is argued as being helped by having relationships that counterbalance the stress experienced in clinical practice (Grant and Kinman, 2014; Kinman and Grant, 2011).

Within the literature there has been limited discussion about midwives' experiences of providing emotional support in midwifery care and the effect it may have on them personally. Individuals who

are emotionally resilient are said to be psychologically flexible and optimistic, with their problem and decision making skills being enhanced (Grant and Kinman, 2014; Kinman and Grant, 2011). These authors also identified a number of attributes that were associated with emotional intelligence including self-awareness, self-efficacy, reflective ability, optimism, effective coping skills, a commitment to professional values and work-life balance. The participants in this study discussed many of the attributes described by Grant and Kinman (2014). These attributes seem to be important for the student midwife to successfully navigate the midwifery programme. There was considerable discussion about how the attributes required for emotional intelligence were related to the individual's personality, with which they entered the midwifery programme.

Whilst midwifery is a profession that offers variation, it also includes uncertainty. A student midwife needs to be able to cope and thrive irrespective of what is happening in midwifery practice. The participants in this study provided a number of examples of how varied their clinical experience was from day to day. Therefore, it could be suggested that midwifery students need to be of a certain personality and one that can manage uncertainty.

Grant and Kinman (2014) proposed that experiential learning supports the development of emotional resilience by the learner observing how experienced practitioners cope in a variety of situations. Experiential learning in this context is achieved in the clinical placements. In this study the students recounted how they had observed midwives' reactions to a variety of scenarios they encountered whist looking after women and their families, so that by 18 months into the programme they were beginning to understand what was required of them and successfully adopt techniques to support their coping strategies.

There were also a number of strategies described in this study to illustrate how the students coped on the programme and '*left at the door'* what was going on in their personal lives. It was suggested that the ability to '*compartmentalise*' was important in order to keep the different parts of their life separate; this reflected the work of Nolan (2014). The participants discussed that compartmentalisation could be achieved through ensuring a range of activities were pursued when they were not on placement.

The findings of this study clearly have synergy with the analogy of the '*midwife's hat'* (Nolan, 2014) in terms of what the participants did to cope emotionally at the start of the shift and when the shift was completed. This separation of work and personal life seemed key to how the students coped with their different roles and responsibilities and a way to protect them from the emotional challenges midwifery demanded of them. Self-protection against challenges appears important as McGowan and Murray's (2016) literature review concluded that there was weak evidence that resilience was key to decreased burn-out. However, it was clear that the participants agreed that showing emotions in midwifery was key to be able to demonstrate compassion to women and identify with what they were going through during childbirth.

The participants described what they did to establish a '*balance*' and the need to be '*strict*' and '*self-regulated'* to acquire equilibrium between home and work. This concurs with Maher's (2013) work that suggested that there were three components to achieving a balance namely: social, organisational and personal. To cope with the reality of the programme and clinical practice, the students recognised that there was a need to maintain a life outside of midwifery in order to achieve balance and perspective. One student vividly used the analogy

of building a tower of play blocks to illustrate all the competing demands she had to deal with. She described how she would build up the tower quite successfully but bricks would fall down requiring her to build the '*tower*' up again. The bricks represented all the aspects of her personal and midwifery life, which needed to be in place for her to succeed. Other students echoed this by expressing that they felt that if things were going wrong in one part of their life, they needed the other part to be positive otherwise the demands were overwhelming.

The actions of maintaining a good work life balance and reflecting on practice is a key theme in this study and is reflected in Alghamdi and Jarrett's (2016) work. Robertson et al (2016) concurred that not having control over one's working schedule made acquiring balance between home and professional life difficult. Crowther et al (2016) described that being '*self-determining'* is demonstrated when individuals have control over their working conditions. Additionally, these authors described how midwives adopted strategies to try and develop resilience in others. The student midwives in this study were clear about the importance of looking after themselves and this was achieved by gaining a balance between their personal and professional life. Therefore, it is possible that resilience in midwifery requires other traits such as adaptability to protect the individual from the negative effects of current practice and moderate the negative effects of stressors. Next the development of student midwives' resilience in this cohort will be considered.

5.3 The development of resilience in student midwives

5.3.1 Student midwives' resilience - the True resilience scale©

Using the resilience scale in this longitudinal study, demonstrated some interesting trends in the development of resilience in the cohort over the first 18 months of their programme. The pattern of the scores gained across the three occasions when the score was completed was key in answering one of the research questions for this study, namely '*does resilience increase or not over the first 18 months of the programme*?'

The responses to seven of the questions showed an increase in score over the three occasions the scale was completed by the participants. The change made by the participants towards the seven statements is indicative of the finding that the students were continuing on the programme as they felt they had made the correct career choice. There also seemed to be a pattern in the grouping of the statements in terms of determination and commitment. The highest average score from the 25 statements was 5.5 for the two questions '*If something is worth starting I'm going to finish it*' and '*Looking back at my life I feel satisfied*'. If applied to these participants and whether they had made the correct choice to become a midwife, this high score in the True Resilience Scale© could be argued as particularly relevant in terms of their commitment to complete the programme.

The lowest average score was 4.2 for the statement '*I can say what I am good at*.' This score has the potential for the student midwives on the midwifery programme to lack confidence in their own abilities. Where the scores increased then remained static it could be argued that student midwives need to have more confidence in their own abilities. Confidence could be the coping strategy that was needed in those students where resilience had remained static 18 months into

the programme, in contrast to the rest of the student cohort. Additionally, the low score in this element may be indicative of a reduced ability for the student midwife to reflect in and on practice (Collington and Hunt, 2009). This is of interest as the participants in this study stressed the importance of reflecting to develop resilience.

The smallest increase in score was in the question '*I rely on my sense of humour to improve my outlook',* which changed from 4.4 to 4.6 over the 16 month period. This assessment may not be such a significant trait to hold in midwifery as it does not align itself particularly to the professional traits demanded of a midwife, namely the 6Cs: care, compassion, competence, communication, courage and commitment (NHS, 2012; NMC, 2015). Therefore, there are some attributes demonstrated in the True Resilience Scale© scores which are perhaps more likely to be required to sustain the midwifery programme and become a successful midwife; all of these particular attributes had increased in this cohort of student midwives.

The responses to nine of the statements increased then decreased over the 18-month period of the study. The applicability to midwifery of the increased then decreased trend is that this group of statements have the potential to indicate how a student is reacting to the programme overall. For example, within the curriculum the aim is to develop critical, analytical midwives and yet in this survey the scores for the statements '*I can see most situations from different points of view'* had initially increased and then decreased. One possible explanation for the increase and then decrease in scores was the stage of the programme when the third and final survey was completed. The second year of the programme is demanding for student midwives where there has been an increase in expectations for both theory and placement (Lovegrove, 2018). From personal experience, the initial excitement of commencing the programme has often been lost or

diminished by the second year and, although students remain committed, the reality of the professional responsibilities of a midwife becomes evident and for some can prove quite daunting.

The two responses that decreased then increased, namely '*I'm not upset for too long when life doesn't go my way'* and '*I am excited about the plans I have'*, are of interest in terms of perhaps demonstrating that at 18 months into the midwifery programme these students were still committed to midwifery. This commitment to midwifery was in spite of being adversely affected by the initial reality of practice and/or the programme. Additionally, the statements also demonstrate determination in student midwives who will not give up even when things are challenging.

Overall, resilience appeared to increase in this cohort. Pairwise comparisons revealed that there were significant differences in True Resilience Scale© scores between the first and the second completion (p= 0.034) and time one and time three (p= 0.002); there were no significant differences between time two and time three (p=1.0). Taylor and Reyes (2012) found, over one semester, two measures on Wagnild and Young's True Resilience Scale© had statistically increased in the statements '*perseverance and existential aloneness'*. These authors explained these changes as the students potentially increasing their determination and self-efficacy to succeed. Nevertheless, it could still be argued that this can only be supported if the right conditions are in place and are experienced.

An increase in resilience was also reflected in the responses of the midwifery student participants in both the focus groups and one-to-one interviews. The participants' belief in their individual resilience was demonstrated where they described instances on the programme being a test, such as when they had had a very demanding clinical

shift or when caring for women who had experienced fetal loss. Additionally the theoretical assessments were also testing their resilience to cope with the demands of the academic work.

Therefore, in this study cohort, using a resilience scale, resilience was reported as developing over the first 18-month period of their undergraduate programme. It was recognised that assessing resilience at the 18-month point in the programme may have had an influence on how these students reported their resilience scores, as the second year of the programme was reported by them as being both challenging and difficult. The opportunity to extend the period of reporting, such as to the end of the programme, may have produced different results. As this resilience scale has been used for the first time with midwifery students, further studies using the scale with a greater number of student midwives are needed to compare and contrast with the findings of this study.

In the comparison of a sample of student midwives, in terms of their resilience scale scores and what they expressed in the focus groups, there seemed to be some contrasting results. In the students that increased their resilience scores, or remained static, their contributions in the focus groups appeared to demonstrate good insight into their resilience and how it had increased or been maintained. In contrast, in the sample of students whose scores had decreased between eight and 18 months of the programme, their contributions did not reflect this change. Therefore, in this sample it could be argued that the use of the True Resilience Scale© was a valid measure in the students who recorded that their resilience was increasing or retained, but not for those whose resilience score had decreased. Nevertheless, it is recognised that the students were unaware of their scores when they were taking part in the focus

groups and that the results in both the scale and the focus groups may have been different had they known their individual statuses.

5.3.2 Student midwives' resilience - biographical profile, academic success and age

McGowan and Murray (2016), when reviewing resilience research, found that there was a weak association between resilience, hardiness, academic success and reduced burn-out, but reported that some of the studies were conflicting in their results. In contrast, in this study all of the students were achieving high academic scores as well as reporting resilience. At the 18-month stage of the midwifery programme, 16 of the participants (almost 90%) had average marks between 60-69% and 70% plus. However, it is not possible to determine whether the students' high achievements were as a result of being resilient, or being a high achiever. It could be argued that those with high assessment scores had an affect on their perception of their individual resilience, potentially influencing how this cohort completed the True Resilience Scale©. Therefore, it is recognised that more research with student midwives is needed to demonstrate whether there is an association between doing well academically and being resilient, as this was not demonstrated in this study.

Sull et al (2015) used an earlier version of Wagnild and Young's' True Resilience Scale© with employees in one large UK NHS Trust and found that there was significant association between age, gender and resilience with females and older employees, demonstrating higher resilience. Interestingly, resilience levels were not correlated with absence levels due to sickness. These authors suggested that resilience may not be the key factor for health and well-being but there may be other protective factors such as job role and number of hours worked per week. However, in this study with student midwives, a link between biographical details, assessment scores and resilience

scores was not found, even though the participants' scores did increase overall during the first 18 months of the programme. The participants also identified that they had developed between year one and year two, although it was not consistent at times during the study period.

There is some evidence in the literature that a student's age has been found to significantly predict performance, with mature students performing better and having higher satisfaction rates (Ansari, 2002). Hayden et al (2016) also found that mature students performed at a higher level but there were complex relationships between intrinsic and extrinsic factors that affected their success. All the student midwives in this study agreed that they needed to develop their own *'toolkit'* to help them cope with the challenges of midwifery practice and have fulfilling careers (Grant and Kinman, 2014).

The mature participants in this study also described specific challenges they had experienced. However, it was noted that the age of the participant did not appear to be relevant in how they scored themselves. Time management, in this study, was reported as being important to successfully balance both their professional and private lives. The mature students particularly seemed to be the ones that had many competing demands requiring them to '*juggle many different balls.*' They described being surprised that whilst they thought they had been mature and resilient before becoming a student midwife, they believed both traits were developing further as they progressed on the programme.

5.3.3 Student midwives' resilience – professional identity and philosophy

This cohort of student midwives described how they experienced challenges at times, where they felt temporary self-doubt in their

ability to be successful and become a midwife. This was also articulated in Lovegrove's (2018) study, which found that self-doubt and the behaviours of midwives had a significant impact on students and influenced their decision whether to continue on the programme. Lovegrove (2018) described the period of transition from a third year student to a newly qualified healthcare professional as being a '*flaky bridge*'. From this study of student midwives, it is argued that there is a similar '*bridge*' when the student first enters into the programme and when they integrate into the profession and adopt their professional identity (Lovegrove 2018:69). Therefore, there should be proactive measures in place to support this transitional period.

Hunter and Warren (2014) reported the trait of self-efficacy, which they argued was not frequently aligned to resilience. The participants in this study discussed the importance of confidence and belief in oneself to be able to become a midwife, particularly early on in the programme. Their passion for midwifery appeared to be a key component in their self-efficacy. Additionally, 16 months into the programme, they felt that they had transitioned and adapted to take on the identity of a midwife and their own philosophy of midwifery practice. They felt that they had adopted a positive mind-set to avoid dwelling on things when they found situations difficult or received less than constructive feedback from their mentors. The findings of this study appear to concur with Hunter and Warren's (2014:930) reporting of the significance of professional identity in resilience, professional belonging and the '*love of the job'*. Additionally, these authors discussed the importance of resilience during the '*critical moments*' in a midwife's job, particularly when an adverse event was experienced (Hunter and Warren, 2014:932). It appears from this study that these '*critical moments'* were prevalent in the student midwife's journey and it could be argued that if these experiences are not dealt with fully

and appropriately then it may be harder to do so when the student becomes a qualified midwife.

Crowther et al (2016) concluded that the relationships the midwife developed with women, families and colleagues were key to their individual resilience and sustainability. In this study the students provided detailed accounts of their relationships with women and midwifery staff. The students talked at length about their relationships with women and the importance of providing evidence-based care that was compassionate. Therefore, it could be suggested that where models of care do not promote relationships and where there is tension between staff in the maternity settings, resilience is jeopardised. In seminal work by Niven (1994), labour was described as all encompassing, but midwives can offer support to help women to remain focused and not become overwhelmed.

Literature also discusses trust and confidence building as an essential component in the midwife and woman's relationship rather than resilience (Leap et al, 2010; Lyberg and Severinsson, 2010). Additionally, the phrase '*professional caring'* has been used to describe what is fundamental to midwifery, requiring the midwife to have wisdom, competence and sound interpersonal skills (Dahlberg and Ingvild, 2013:408).

The participants in this study had also observed a variety of approaches adopted by the midwives to support the women in their coping and reactions; the midwives that they most admired and were successful were described as those that maintained an air of confidence in the woman at all times. Arguably, the term confidence was used to describe both the resilient midwife and how the woman was behaving.

Emotional support has also been cited as a key attribute to provide effective care for a woman in labour (Nilsson et al, 2010) and this study's findings reported that women required resilient midwives. The study's participants considered that midwives needed to demonstrate their human side, being calm and compassionate and being able to control their emotions. It was also suggested that a midwife and the woman should work as one unit, the strength of this union making the woman stronger. Therefore, it is proposed that a midwife requires resilience to be able to effectively promote a woman's trust and confidence in the care they are receiving. Arguably, if midwives have to manage their emotions they might not be able to practise in the way they want to and it could put them under a lot of pressure to ensure they retain their philosophy of care (Hunter 2004). Being able to practise as an autonomous midwife, adopting true-woman centred care, has been, to date, very difficult to achieve in midwifery when practising in the NHS. Nevertheless, the new ways of working, for example providing continuity of care, potentially reflect the benefits for the individual midwife as well as the woman (Cumberlege, 2016).

This study also found that students expressed a strong woman-centred philosophy. They described instances where they were witnessing a midwife's practice that was at odds with their own philosophy. Additionally the effect of organisational culture had a negative impact on the student midwives. This conflict in midwifery practice meant that the students were challenged to consider how they might need to react to promote women centred care in their practice. This is concerning for student midwives in terms of how their view of midwifery could change and could risk their continuation on the programme if conflicting views could not be resolved. This reflects the seminal work of Goffman (1968) who proposed that when the needs of the institution become the primary focus, it does so at a detriment to individuals.

An unexpected finding in this study and one that was not considered when developing the research questions was the suggestion that resilience was seen as an essential trait to be able to care effectively for childbearing women. Niven (1994) discussed how women used coping strategies in labour rather than trying to concentrate on personal control. This suggests that a key role of the midwife is to be supportive of the coping mechanisms that a woman is adopting when in labour; being adaptable and using resilience could promote this more effectively.

5.3.4 Student midwives' resilience - interventions

There is much written in the literature about interventions that claim to promote resilience. Rogers (2016) found that although some of the interventions seemed to have some positive effects, the limitation of the studies was that they were not longitudinal so it was not clear whether there was a long-term sustainable effect on resilience. Pines et al (2014) found no statistical significance after interventions took place. Kreitzer and Klatt (2017) proposed that self-care needed to be addressed in curricula but their review of the literature demonstrated that evidence for interventions remained inconclusive. Therefore, it remains uncertain whether interventions would assist a student midwife's resilience. This group of students had received sessions on resilience and how to support themselves. However, the students admitted that they could not remember them very well, implying that they had had a weak impact. The participants were clear in their accounts that resilience could not be taught, but agreed it was a trait that could develop given the appropriate conditions in a supportive environment.

Pezzaro and Clyne (2017) were concerned with work-related psychological distress and reviewed a range of interventions in the

literature. These authors also found there was little evidence to support interventions with midwives and student midwives. Although some positive outcomes and experiences were reported, Pezzaro and Clyne found that the limited international studies reported were not of high quality and the population samples were omitted. They recommended further research that focused on midwives and student midwives.

The participants in this study did not talk about any particular intervention. There was discussion about a number of personal strategies that could support resilience development such as having a sound knowledge base, self-regulation and time management. Additionally, support was seen as key to be able to deal with difficult experiences. In this study, looking after oneself was seen as a positive step towards resilience, as well as being able to consider what should be given time in the curriculum.

Therefore, the question of interventions to promote resilience remains unresolved. Arguably, the process of reflection and support seems more relevant to healthcare professionals than interventions, as the promotion of training to be resilient seems too simplistic. This study found that the process of reflection and support from significant others were particularly key to this cohort. The next two sections will consider reflection and reflexivity and their relationship to the resilient student midwife.

5.3.5 Student midwives' resilience - reflection and reflexivity

Reflection and reflexivity were key components for developing and maintaining resilience, which these students reported were included in the curriculum. This reflects Cope et al (2016:3) who suggested that when an individual tells their story it is cathartic and '*frees*' them from keeping the experiences to themselves. These authors also stated that

when a story is told, an individual is able to make sense of what happened, as well as putting their own meaning on it.

A number of authors have concluded that reflection enables nurses and midwives to address difficult situations in practice and foster resilience (MacDonald et al, 2012; Chen, 2010; Edward and Hercelinskyj, 2007). Reflection was discussed at length in this study as it enabled a perspective to be gained on situations. The descriptions of what the students were experiencing in practice were very vivid and the students demonstrated some emotional responses when they were recounting their experiences. Reflection was the process that enabled the students to both rationalise and be realistic about a way forward in order to develop their midwifery practice. The participants were not in doubt that reflection would help them develop as students and subsequent midwives and harrowing experiences were not to be shied away from. Grant and Kinman (2013) proposed that reflection was multidimensional and in order for students to be able to emotionally reflect on practice, support was required. Time within the curriculum should be offered where reflection can be directed by midwifery academic staff that have had similar experiences.

The students in this study suggested that if reflection was to be successful it needed to be conducted in both a positive and negative way, with some time elapsing after the event in order to gain any benefit. The value of mentors supporting this process was also highlighted as being beneficial.

It appears that when the students in this study used the term '*reflexivity'* they were describing how they challenged their own assumptions about midwifery practice, attending to their knowledge base and the situation. Additionally, by being reflexive an individual is examining his or her own motives, actions, feelings and reactions that

go further than simply reflecting. A low level of reflexivity can mean that an individual is at risk of being '*shaped'* negatively by their environment. Therefore, nurturing reflexivity in midwifery practice is proposed as a sound tool for devising solutions for any future challenges.

One unexpected finding, that became evident during the focus groups, was that a number of respondents reported how beneficial they found being involved in the study and having the opportunity to share their experiences of being a student midwife. The students described, in this study, the benefit of being participants was that they were given time to discuss issues with others in a way they had not experienced on the programme to date; this promoted the process of reflection.

Whilst reflection and reflexivity were described by this cohort of students as being essential for the development of resilience, it was the support of others that was considered in the most detail. The relationships with significant others will be discussed next.

5.3.6 Student midwives' resilience - relationships with significant others

The students' mentors were described as being varied in their approach, some having a personality that made working with them very challenging. The students described that at times they were under such pressure and scrutiny they felt they were on a '*three-year interview*'. Experiencing pressure does not seem conducive to learning if the student is nervous in the clinical environment and having to adapt their behaviour. '*Having a go'* and trying not to make a mistake in doing so appeared to put undue pressure on the student. A real concern was that they did not believe they could make a mistake even though they were learners and making a mistake was inevitable. Whilst

mentors seemed to vary in their approach, the students recognised the need to have a positive relationship with them in order to succeed. It could be argued that mentors needed to demonstrate resilience to student midwives in order to support them effectively.

Of particular concern, however, was the students' belief that they should not get things wrong. The findings indicated that the students felt they were being constantly assessed and under scrutiny. Whilst they did not explore the specific consequences of this, the sense of fear may have had a significant impact on the relationship with their mentors. For example, whilst trying to impress their mentors, they did not want to admit when they found things difficult or needed further support to become proficient.

Lovegrove's (2018) study on recruitment and attrition across a range of professions found that students often felt overwhelmed with the workload and that had an effect on their mental health. Additionally, whilst the participants had experienced enthusiastic mentors, some had encountered negative experiences. Lovegrove's (2018) study vividly described the poor behaviour of some midwifery mentors, which included bullying and belittling. Midwives also actively challenged a student's decision to become a midwife (Lovegrove, 2018). Whilst Lovegrove's (2018) work did not specifically mention that students were nervous about making a mistake, there are similarities with the experiences of these students and those in this midwifery study.

A midwifery student cannot be separated from their social environment. They are not just a student but also a daughter/son, a friend and possibly a wife/husband or a partner. Examples were given by the participants of some of the tensions that the programme was causing between themselves and others. The importance of preserving

these relationships and those in the healthcare setting whilst the student is on a midwifery programme cannot be understated and they may be key to the student's success. Relationships with significant others was a key theme in this study, not least the support that partners and family members were giving them. Crowther et al (2016:45) stated that relationships were key to resilience and '*self care'*; including those with women. These authors considered maternity services should be arranged so that effective relationships with women and colleagues could be fostered.

McAllister and McKinnon (2009) discussed how effective connections with peers could support the development of resilience. Additionally these authors supported contact with others to facilitate coaching and role modelling. The students in this study recognised that a range of significant others played a key role in supporting them through the programme; these included family, friends, other students and personal tutors. This study's participants felt it was important to be able to '*bounce*' ideas off each other as well as empathise with each other when experiencing difficulties on the programme. They were very mindful of the professional restrictions in terms of talking about their experience but, nevertheless, gained support from others who would understand their predicament. However, partners and family members, whilst essential to encouraging the student midwives, were also described as having to adapt to the change of routine and expectations whilst the individual was studying the midwifery programme.

5.3.7 Student midwives' resilience – *'reactability'*

The majority of the students in this study agreed that they were resilient. Many examples were given of the very difficult situations they had encountered, for example, learning how to cope with the death of babies, which is reported in the literature (Alghamdi and

Jarrett, 2016). The students described how they were taking positive steps to develop their emotional resilience in the new environment of midwifery, rather than expecting that their coping mechanisms used previously would suffice. Taking positive steps to becoming resilient seems to contradict an earlier discussion by the participants where they had stated that resilience could not be taught. However, it could be suggested that the participants were arguing about the importance of taking personal responsibility to develop strategies that would aid themselves when there were emotional challenges. It is suggested that a student midwife's '*resilience tool box'* supports the concept of how students cope with situations whilst on the programme, as well as their outlook and the strategies that they adopt (Nolan, 2014). Strategies covered included: maintaining positive mental health, taking physical exercise, maintaining a balance between the demands of the programme with their home life, and any other external stressors. This study's findings reflected the elements of the '*resilience tool box',* concurring with Grant and Kinman (2012) who agreed that an individual should be proactive rather than reactive in their approach to difficult situations.

Midwifery clinical practice has many challenges. Shifts in practice are unpredictable and a midwife has to learn to deal with uncertainty on a daily basis. The findings of this study reflected the variability of midwifery practice and described how a midwife needed to be proactive to any challenges, digesting what is happening in order to know how to react. The importance of a midwife being adaptable in their reactions to what they encountered was also found. Findings from this study suggest that being adaptable seems key to resilience in student midwives. Adaptability can assist them to learn from challenges and avoid experiencing disquiet or doubt in how they would deal with the same situation should it occur again.

In an attempt to capture the complexity of what occurs when a student midwife successfully navigates the midwifery undergraduate programme, the participants used the term '*the reactable student midwife*'. This term captures the need for flexibility in approach and the ability to adapt and cope. These are key traits for a student midwife and this is vital to them being resilient. The discussion about the concept of adaptability is also presented in Robertson et al's (2016) comparative review, which proposed that positive adaptation occurs by the individual having some specific traits, together with the experience they gain as a professional. These authors found through the review that resilience was more than not '*burning out'* but that the individual needed to progressively adapt and develop personal resources (Robertson et al 2016:423). Positive influences in the development of resilience were identified as '*social resources'*, such as support from family and peers, as well as physical activity. This study of student midwives also found that resources outside of the professional environment were key to developing and maintaining resilience. Many of the features that Robertson et al found in the literature were similarly demonstrated in the findings with student midwives.

Additionally, the trait of adaptability may encourage an individual not to have fixed ideas about what will happen in the future, thus protecting them from disappointment and disquiet when things are not as they predicted. Resilience has also been suggested as being present in those individuals that accept what is happening and apply adaptive measures to respond flexibly (Coutu, 2002).

Therefore, it appears paramount that student midwives recognise the opportunities for promoting their resilience and understand the threats to it, in order to be able to function effectively in a potentially disabling environment. Additionally, how students integrate into the

environment appears important, which further reflects the adapted work of Tinto (1975).

5.4 Implications of this study for theory and midwifery education

Two key theories were reviewed prior to the commencement of the programme and they were both considered to be of potential benefit to the understanding of why student midwives persisted on the programme despite challenges. Additionally, the theories were reviewed in relation to the findings in terms of their relevance to resilience in student midwives and the primary focus of this study.

5.4.1 Student midwives' resilience by broadening and building

The students were consistent throughout the study in describing how they were resilient and they recognised the need to look after themselves in order to navigate the programme. A number of key traits were found in this study that are considered as important to foster, namely: adaptability, compartmentalisation, remaining passionate about midwifery, being proactive and understanding. It is additionally proposed that Fredrickson's (2004) '*broaden and build'* theory of positive emotions is of importance in promoting resilience in student midwives. Whilst resilience was seen as not being able to be taught, the students agreed that it needed to be developed specifically for midwifery practice and this reflected Fredrickson's *(*2004) work. Resilience was not seen as a static concept but one that could develop throughout the midwifery programme. The students were very clear that a student midwife needed to be responsible for their own resilience and be proactive in maintaining it. Frederickson's (2004) '*broaden and build'* construct seems to be reflected in what the study's participants discussed particularly in relation to the importance of positive emotions and well-being. There was agreement in this study that resilience changed from day to day depending on what was happening in the participants' personal and work life.

Resilience was described as fluctuating and there was a need to look after oneself and access support when required.

A question that was not specifically considered in this study is how much adversity in midwifery practice can a student midwife sustain, over a period of time, until they eventually find they are unable to cope with the programme. As previously discussed, within a working day, midwives' experiences range from the joy of a couple becoming parents for the first time, to the acute sorrow of a baby dying. The study proposed that different levels of resilience came into play during different situations; for example, how emotions were controlled.

The students in this study discussed in depth how they were '*building'* and developing a knowledge base to deal with crises using their positive emotions in order to function effectively and, as a result, building their resilience. Next Tinto's (1993) model will be reviewed in terms of how it aligns to the study participants' integration and adaption into the midwifery profession.

5.4.2 Student midwives' resilience through integration

The integration of the student, both into the university and the maternity settings whilst adopting the professional attributes of a midwife (NMC, 2015), appears to be paramount. The students provided many examples that demonstrated how they were needing to integrate in the programme and particularly into the placements, which changed frequently, necessitating them having to work with a range of different people and experience different working practices. The students described the first year as being important for developing confidence and their belief that they could be a midwife. These findings reflect the developed work of Tinto (1993) in terms of having social integration. By 18 months into the programme the participants described themselves as being '*professionals',* which

mirrors the social integration that Tinto (1993) was proposing. Additionally, where the students in this study described '*passion*', despite the relentless nature of the midwifery programme, it implies their '*integration'* into the midwifery profession (Tinto, 1993). This was further illustrated when the participants talked through the process of negotiating and adapting to working with different mentors as well as the effect that disillusioned mentors had on them.

As a result of this study, Tinto's (1997) model was further developed to reflect the position of the clinical placements that are undertaken for 50% of the programme (see appendix 14) and the importance of the '*classroom*', which can be interpreted to mean the practice setting. The adapted model reflects the place of integration into the midwifery profession as a pre-requisite to being able to demonstrate professional commitment to becoming a midwife. Tinto argued that a person's characteristics were integral to them having a commitment to the goal of completing their course as well as to the particular institution. This author proposed that students use a cost benefit analysis to assess their experience at university with social and academic integration being important factors as to whether a student perseveres or leaves the programme. Additionally, Jackson et al (2011) proposed that the students who coped better with stress in practice had a strong sense of professional identity.

Arguably, an individual who is more at risk to attrition from a midwifery programme could have greater impulsivity, less emotional commitment to education, and more anxiety and restlessness. Owing to the limitations of this study, these traits were not explored in depth but, based on the data, the significance of being passionate about midwifery, the effect on their emotions and how they had learnt to cope with the demands all seemed important.

Tinto's adapted work could also have some significance for how midwifery students are selected, to explore their motivations for wanting to become a midwife. For the prospective midwifery student, there may be a difference between what they believed midwifery to be and the reality of it when they are on the programme (Hughes, 2013) as they interface the two environments, and perhaps different cultures, of academia and clinical practice. Most of the cohort in this study had had some work experience that could be transferrable into midwifery, which should have been good preparation for the programme.

This study found that it was difficult to be totally prepared in advance for what student midwives were going to face in clinical practice and the only true preparation was to experience it. Nevertheless, the stark reality of the programme and midwifery practice meant that this study found that it is difficult to fully prepare an individual for what they will encounter, resulting in some students in their cohort leaving quite early on in the programme.

In Tinto's (1997) updated work, the interplay of variables such as persistence, involvement and interaction were considered. This author argued that academic integration was linked with social integration. This has resonance with midwifery that demands both academic attainment and the progressive development into the role of a professional midwife.

Many of the students in the study cohort were involved in a range of extra-curricular activities including being student ambassadors at the institution's open days and selection events, which could be argued as demonstrating commitment to the university and wanting to promote it positively.

5.5 A model of resilience for student midwives

This study was important as, to date, the concept of resilience has not been defined for student midwives. In the literature there appears to be only one proposed definition of resilience for nursing students, namely:

> 'Nursing student resilience is an individualised process of development that occurs through the use of personal protective factors to successfully navigate perceived stress and adversities. Cumulative successes lead to enhanced coping/adaptive abilities and well-being'.
>
> (Stephens, 2013:130)

Arguably, this definition could be applied to a variety of contexts and job roles, as there is no reference specifically to nursing and what a nurse has to deal with. One specific aim of this research study was to consider how student midwives defined resilience. The findings of this study do not seem to totally align with Stephen's (2013) definition and potentially support the view that midwifery students require their own definition of resilience.

McGowan and Murray (2016) concluded in their literature review that finding an operational definition of resilience was complex. Nevertheless, as a result of this study's findings, a conceptual model has been developed, based on the study participants' contributions. This is presented in figure 2.

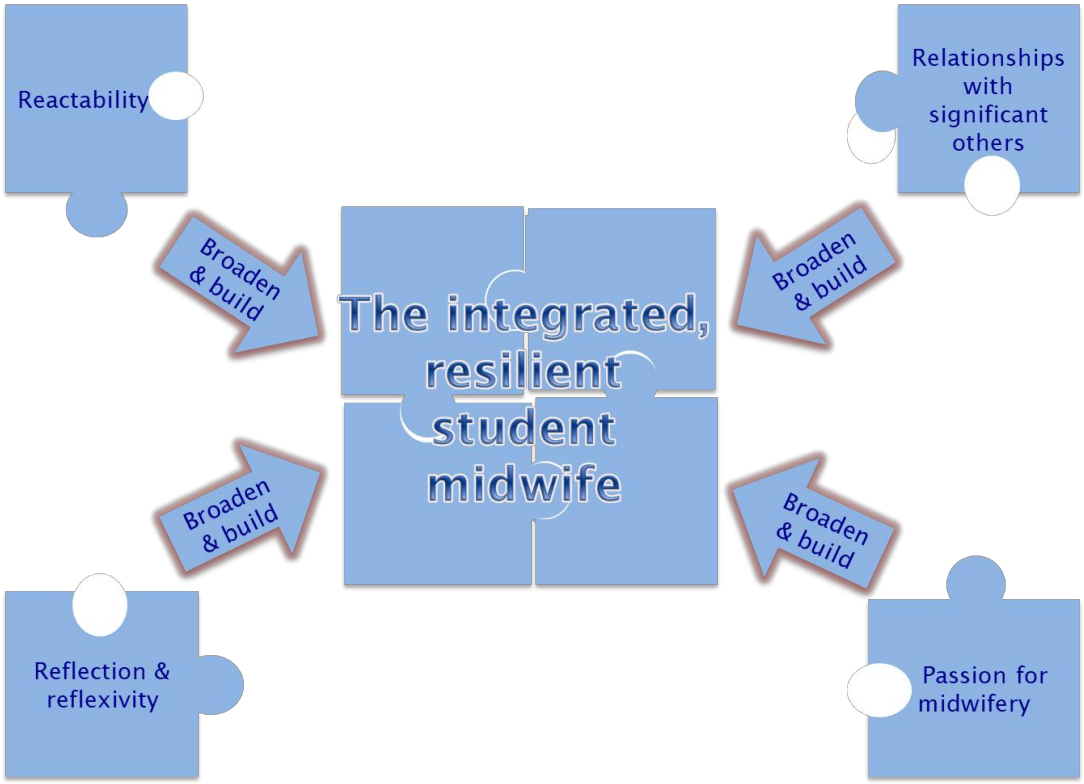

Figure 2: A model of resilience for student midwives

The model of resilience for student midwives presents four essential components, namely: reactability, reflection and reflexivity, relationships with significant others and passion for midwifery. It is proposed that these four components will together support student midwives to broaden and build their resilience, which will result in the successful integration into the midwifery profession.

All components are interdependent, integral and essential to resilience for student midwives; without one component a student midwife's resilience will potentially be weakened. None of the components are more important than the other and they are not hierarchical in nature.

The component of integration in the model, which is aligned to Tinto (1975; 1997), is also reflected in other literature, albeit that different terminology is used. For example, Crowther et al (2016) considered

how midwives demonstrated their passion for their work. These authors also suggested that by personally identifying with their profession, midwives were able to make a real difference in caring for women and babies.

Cope et al (2016) also found that to be resilient required effort as well as a sense of commitment and passion within the professional role. These authors discussed the meaning of work for women who often merged their personal and professional selves in their jobs. In this model, integration into a professional life and midwifery as a career choice is the key to success.

To be able to make sense of what is happening in midwifery care, understanding is required in order to work out how to deal with the issues, thus adopting a proactive approach. Action could include the individual personally reflecting to make sense of what is happening to them as well as seeking external help. The process of reflection and reflexivity enables a student midwife to recognise when action should be taken in order to move forward successfully. Therefore, it is suggested that the more informed a student midwife is, by developing their personal insight, the more resilient they become in midwifery.

Resilience does not mean that an individual is not affected by a difficult situation but knows how to respond and gain closure. Therefore, when the student midwife asks for support and guidance it should not be seen as a sign of weakness but a strength and part of their resilience; their relationships with significant others play a key role here.

Therefore, this unique model of resilience for student midwives is presented as a framework for student midwives and their significant others to consider strategies to foster resilience. If students are

introduced, using the framework, to the essential components of resilience for student midwives, then they consider whether they have these traits and in what measure, so they can take specific steps to develop them further. It is proposed that the overarching component for the student midwife is integration and if all other components are aligned, then the student midwife is more likely to feel part of the profession and will wish to complete their undergraduate programme and practice as a midwife.

5.6 Conclusion

Most attrition from the midwifery programme has been in the first year when the individual encounters the clinical placement for the first time (Lovegrove, 2018). Thereafter, it tends to be academic failure or personal health and circumstances, which forces the student to leave. Maher (2013) also argued that individuals who feel the need to adopt resilient behaviours might also choose to opt out of a situation completely; for midwifery this may mean leaving the midwifery programme or subsequently leaving the profession.

Throughout this discussion, the concept of resilience has been explored in terms of the impact it has for a student midwife navigating the undergraduate programme and becoming a midwife. Using the True Resilience Scale©, the students in this study were found to have developed their resilience within the first 18 months of the programme, which they confirmed through their discussions in the focus groups and one-to-one interviews. The study participants clearly articulated a definition of resilience and its relevance to student midwives specifically. Resilience was viewed as being key to student midwives and involved being supported and learning how to deal with difficult situations in midwifery practice. Having certain resilience attributes, for example, passion, adaptability and being reflective, enabled these students to cope and develop into qualified midwives.

A range of strategies have been presented to consider their place in supporting student midwives to develop their coping mechanisms and resilience, the most important being to learn how to reflect. The student midwives in this study did not shy away from learning how to deal with the different challenging scenarios that they would subsequently encounter as a midwife. Ensuring preparation for real life midwifery practice was seen as a very important component to be addressed within the midwifery curriculum.

Tinto's (1975) adapted work is felt to be a useful framework for curricula activities as it has been aligned to a person's attributes and their ability to integrate into the academic and clinical environment. The UK NHS environment is a pressurised one, where current financial pressures and reorganisation are putting pressures on its workforce (Sull et al, 2015). In a recent membership study, midwives reported feeling stressed due to having a heavy workload, staff shortages and not having enough time to do the job (RCM, 2017b). The RCM's survey concurred with the NHS Staff Survey (2017) that staff could not absorb any further work pressures and that staff satisfaction had decreased since the previous survey. An unanswered question from the RCM (2017b) survey is whether having resilience would make a difference to NHS staff.

If it is accepted that it is unavoidable that students will encounter difficult situations in practice, it is critical to support them effectively to be able to cope when challenges arise. It is proposed that the context and complexity of midwifery practice requires its own model of resilience for student midwives. The key components of the model are presented as being essential for student midwives to broaden and build their resilience and integrate into the profession.

Chapter 6.0 Conclusions, reflections, implications and recommendations

6.1 Introduction

This study has produced rich data across all of the methods used in relation to 18 student midwives' experiences of theory and practice over half of their midwifery programme. This final chapter considers the conclusions, my reflections, the implications of the study and its contribution and significance for student midwives and midwifery education. An evaluation of the research study design and the data collection methods are included to review their effectiveness in meeting the aims of the study and answering the research questions. The conclusions of the investigation in relation to the research questions are presented first.

6.2 Conclusions of the study

The purpose of the study was to investigate the concept of resilience in terms of its potential impact on student midwives. The following final conclusions present a summary of the research and the implications for midwifery education and student midwives:

- Challenging the resilience discourse
- Resilience is an '*umbrella*' term
- Resilience cannot be taught but can be promoted

The role of resilience in supporting healthcare professionals' practice is also not consistently articulated in the literature and there appears to be a lack of knowledge regarding the best approach to take to increase the knowledge about resilience (Aburn et al, 2016; Thomas and Revell, 2016).

6.2.1 Challenging the resilience discourse

Descriptions by the study participants about the current culture in the NHS was concerning. It was argued that the promotion of resilience to cope with poor behaviour in the maternity clinical areas is not appropriate. The study participants felt that the way the term resilience is currently being used does more to threaten it in midwives than promote it.

In respect of this cohort, support systems within the university and clinical setting to promote resilience were seen as very important. The NHS is currently a challenging place to work. There is rhetoric about the need for individuals to be resilient to cope with the difficult environment. This study proposes that it is not acceptable to condone poor working conditions or practices and places the ownership on the individual to address the issues of a hostile environment.

The RCM's (2016) '*Caring for You'* campaign aimed to counterbalance the current pressure experienced in the NHS to improve midwives, student midwives and maternity support workers' health, safety and well-being at work. The RCM's campaign promoted positive working environments, which should have zero tolerance to bullying and nurture a compassionate and supportive workplace for all staff. Addressing carers' well-being is proposed to result in having greater capacity to deliver excellent care to women and babies.

Midwifery educationalists should work with their NHS colleagues to address poor practices in the clinical placements and challenges where behaviours are reported as poor. The components of the RCM campaign could be used as a template to promote student midwives' well-being within the educational setting. In this study there was a lot of discussion by the participants about the physical effects of working on maternity placements. This study's participants were not immune

to the pressures in the workplace and were very conscious of the effects this had on their mentors. It is recommended that an audit of student midwives is carried out, in placements who are committed to the RCM's campaign, to assess how students' health and well-being is being considered and supported whilst they are on clinical placement.

A variety of measures would additionally improve working conditions in the NHS, such as improved staffing levels, ensuring breaks are taken, modernising break out areas, focusing on the relationships between managers and all grades of staff to encourage support mechanisms and meeting of individual personal needs. It is suggested that students would also benefit from better conditions being introduced for NHS staff and, as a result, promote it as a positive employer and place to work.

6.2.2 Resilience is an '*umbrella'* term

This unique study has explored the concept of resilience and how it applies to student midwives; resulting in a model of resilience for student midwives. This study has concluded that resilience is a multi-faceted concept that relies on a number of essential key attributes that can support a student midwife with the challenges that they encounter in midwifery practice. The idea that there are different levels of resilience, it is not a static concept and can fluctuate between contexts was supported by the participants in the study. A model of resilience for student midwives is presented that highlights the key individual attributes that are required for the successful study of midwifery. The resilience model presents the individual interventions that will support the development and maintenance of resilience.

It would be helpful to consider the findings of this study with students when they first commence the programme to develop strategies to enable them to recognise how resilience fluctuates. The promotion

and understanding of resilience would encourage them to have realistic expectations of themselves and perhaps avoid becoming demotivated or despondent when they felt they were not coping well.

The True Resilience Scale© was statistically significant in the participants, but the limitations of the study's timeframe meant that it could only be used on three occasions. It is recommended that the scale should be used in future research, across the whole three years of the programme, as a predictive tool of an individual student midwife's resilience.

As the term resilience continues to be in popular use it is important to be clear about its definition for student midwives. The findings of this study present a range of traits and attributes that reflect resilience in a student midwife. It is proposed that resilience for student midwives is an '*umbrella'* term, which covers a wide range of concepts belonging to a single common category. For this study, it is being used as a blanket term, encompassing the range of attributes, which a student midwife needs to develop. It is acknowledged, however, that as a term it does not necessarily give the precise details of the concept.

6.2.3 Resilience cannot be taught but can be promoted

Prior to the study the participants had been introduced to the concept of resilience in a workshop in the early weeks of the programme. However, the students were very clear that they did not believe that a person could be taught to be resilient, rather that knowledge and understanding of the concept was required to enable the individual to be able to react to any challenging situations.

Nevertheless, the findings from this study demonstrated that they had gained something different from being participants and having the opportunity to discuss the concept of resilience in depth. Of interest

to me as a researcher, was that the students shared how much they enjoyed being part of the focus groups and that they found discussing the issues personally cathartic. The cathartic nature of being part of the study appears to align to the recommendation that reflection is an important tool to support the development of resilience. Therefore, one of the recommendations of this study is that activities to promote resilience should have a prominent position in the midwifery curriculum. It could be argued that providing the opportunity to discuss the concept of resilience has a completely different focus to activities that purport to train someone to be resilient. Therefore, student midwives should be introduced to the concept of resilience and be given an opportunity to discuss strategies to improve resilience as a personal tool in stressful environments. It is proposed that the use of the conceptual model of resilience, as presented in this study, will support the better understanding of the term resilience for student midwives and what interventions may assist its development.

Additionally, the development of resilience needs to be considered throughout the student journey and a consideration of which activities should be embedded in the curriculum to promote it effectively. One-off programmes/workshops are unlikely to be effective as resilience was found not to be a constant trait and will ebb and flow depending on what is happening in the student's professional and personal life. Consideration of resilience should be incorporated into all teaching methodologies and support mechanisms that are available to the student, and be student focused based on individual needs.

Midwifery programme leaders should be mindful of the effect of the course structure on student midwives and consider how it could be adjusted to better support them. Midwives should consider their role in being resilient, not just for women, but also for the student midwives who they are supervising.

6.3 Reflections on the research study

6.3.1 Being an insider-researcher

As an insider-researcher undertaking this study I recognised the advantages and disadvantages of this role for the validity of the study. I was mindful of my dual role, being a senior midwife in the division and a researcher, throughout the research process. To ensure that the two roles did not conflict, as Unluer (2012) recommended, the study was not discussed throughout the process with colleagues in the university, nor were they aware of who the participants were. In turn, the participants were encouraged to view me only as a researcher, albeit one that was knowledgeable about midwifery education.

Of particular concern was the potential power relationship between myself and the participants; I was aware that they might be hesitant to be open and honest if they perceived there could be repercussions for them later in the programme. As advised by Breen (2007), I took steps to reassure the participants that anything they shared within the group or individual interview would remain confidential. The participant information sheet stressed that they were under no obligation to participate and that their programme would not be affected if they declined to be involved in the research. I was conscious of Drake and Heath's (2011:28) suggestion that a researcher cannot '*unhear'* what has been shared; therefore, I had to make every effort to ensure my role as a senior educator and that of a researcher were not in conflict or overlapping. This was achieved by being transparent in my actions throughout the research process, to reduce the potential of any other factors influencing the findings (Smith, 2008).

I found that being an insider-researcher was helpful in understanding the nuances of what the participants were discussing, particularly

when they contributed quite complex examples from midwifery practice. Burke and Kirton (2006) described how being an insider-researcher enables more complete understanding and I considered that this was so in this study due to the specialist nature of the conversations.

I took precautions against undertaking a personal tutor role with the participating students. With the exception of one student, I was successful in terms of not undertaking student supportive roles with the study cohort, whilst they were involved in the research study. I kept ethical principles in mind during the study and returned to the issue of consent by the participants throughout. The impressions and thoughts about the study were captured at frequent intervals in a research diary and were only shared with my supervisors.

This study has provided me with the opportunity to develop my skills and knowledge of educational research using a range of methods in a longitudinal study. My confidence in facilitating focus groups grew during the study, as well as the handling and analysis of the data. In addition my professional development as a researcher has particularly been developed through the adherence to ethical principles as an insider-researcher.

Burke and Kirton (2006) discussed the importance of reflexivity for a researcher through questioning the assumptions that are brought into the research. Through adopting this reflexive approach I was able to challenge my beliefs when faced with the participants' contributions. I was mindful that it was important to present the students' views on resilience as closely as possible. Nevertheless, the reflexive process enabled me to develop more complex understandings of what the participants were describing.

6.3.2 Consideration of the research design

- **Recruitment**

Participation in the research study was voluntary. Recruiting half of the cohort was considered to be an adequate number of participants to gain the breadth of data across all the data collection tools. If it had been possible to adopt a different approach, recruitment from another cohort and another university's midwifery programme may have provided the opportunity to compare and contrast different cohorts of student midwives. However, it was recognised that the time constraints for the study made widening the recruitment to include another cohort of student midwives problematic.

Measures were taken to ensure that the students did not feel '*coerced'* into participating (Smyth and Halian, 2008). Direct emails were sent to each member of the selected cohort to invite their participation. The intention of using emails was to give the students the opportunity to decline involvement more easily. The participant information sheet made it clear that their involvement was voluntary and they could withdraw from the study at any time (see appendix 2).

Braun and Clarke (2013:58) discussed the recruitment of the '*usual suspect'* in terms of whether they represent the wider population. In this study, the cohort of student midwives was diverse in terms of age, ethnicity and entry qualifications and it was felt that their contributions would capture a wide range of views.

Recruiting 50% of the cohort initially (a sample of 25 participants) into the study was felt to be sufficient to ascertain the range of views of resilience by this cohort of student midwives. The final figure of 18 participants was just over a third of the cohort. The reasons for

attrition from the study cohort were due to participants leaving the programme, rather than individuals no longer wishing to take part.

Throughout the fieldwork I was pleased to note that all participants demonstrated their positive engagement through their body posture and their contributions to the conversation. Other than when a specific question was asked, the students faced each other and looked directly at the person who was speaking. Prior to this study I had not specifically considered how body language and engagement would have been evidence of their willingness to participate and how this could enhance the richness of the data collected.

- **Effectiveness of the data collection tools and data analysis**

This study provided an opportunity to use a well-validated resilience scale for the first time with student midwives. I was keen to establish whether using a scale would add value to how resilience is determined and whether it demonstrated that it develops in student midwives. Wagnild and Young's True Resilience Scale © has been used widely with a range of groups but this was the first time it has been used longitudinally with student midwives (Wagnild, 2009). The scale was quick and easy to use and demonstrates potential for more widespread use in midwifery programmes. On reflection using the scale in this longitudinal study did enable trends in these students' resilience to be considered. Together with the other data collection methods used in this study, the scale increased the comprehensiveness of the examination of resilience in these student midwives.

The participants freely provided detailed answers and descriptions that generated a lot of data across all methods. It is felt that conducting four focus groups on two occasions and six one-to-one interviews enabled saturation to be reached in terms of the responses

that the students gave (Bowen, 2008). Conducting more focus groups or one-to-one interviews in this study was unlikely to have generated any further insight into the research questions.

Another unique experience for myself as a researcher was realising that not only were responses gained to the questions asked, but also observing the way the participants worked together to produce comprehensive answers (Kevern and Webb, 2001). During the focus groups and the transcription process, it was apparent that some participants contributed more than others. By paying specific attention to the behaviour of the participants, I also became aware that on a number of occasions another member of the group completed sentences for an individual participant. Furthermore, participants often expanded upon the topic of discussion by using an additional example to illustrate the original point being made. They also expanded on what other members of the group had been saying, attempting to make the point being made clearer for the group. It could be argued that this type of interaction was not demonstrating dominance of any one group member, as Kevern and Webb (2001) discussed, but a desire for them to come to an agreement as a group and be supportive of each other's contributions.

The discussion within each focus group was interesting in terms of how the groups seemed to affect the progression of the answers to my questions. The students were all engaged and there were many examples of how they '*bounced*' ideas off each other. I observed evidence of problem solving in the groups that resulted in a slight delay before I received their answer to my question. The problem-solving reflected in the group interaction is suggested to be encouraged by using focus groups (Kevern and Webb, 2001). I observed lively discussion across all focus groups and the one-to-one interviews and the participants seemed eager to respond to my

questions. Additionally, the participants did not simply respond to the questions but were applying critical appraisal to the issues I had raised and as a result, provided rich and detailed responses. On occasions the students' responses did move off topic slightly but were able to be brought back with some gentle prompting by myself.

Using focus groups for this study provided richer data as a result of the collective responses gained. The richness of the data reflected Kevern and Webb's (2001) discussion of the processes that occur in a focus group. It also gave an opportunity for the views of individuals to be listened to by the group before a final conclusion was reached (Stevens, 1996). There was, in the main, no disagreement within the focus groups, but I observed how the answers became more detailed as different participants in the group contributed to the responses (Kevern and Webb, 2001).

In support of my observations, Kanuha (2000) commented that any familiarity between the participants within the transcripts were not evident. For example, Kanuha (2000) found some points vague but, nevertheless, there seemed to be a shared understanding between the participants of the comments made, the innuendoes and the incomplete sentences. I was similarly aware of this in my research.

I found myself echoing the words to ensure I had heard correctly what the participant had said or asked a follow up question to clarify what was being said. From further analysis of the audio recordings and the transcription, I was mindful that the participants frequently talked together and some of them were unable to finish their sentence as someone else had started talking over them. Sometimes a participant could not think of the word they were looking for and another participant said it for them and, as a result, finished their sentence.

The aim of the one-to-to one interviews was to explore further a number of specific points raised by particular participants. On reflection the one-to-one interviews did not expose new data, which was different from the focus groups, but they did provide the opportunity for the participants to give a more detailed explanation of the points they raised. Guest et al's (2017) review of the literature found that some sensitive issues were likely to be divulged during a focus group, whilst others would be revealed in a one-to-one interview. As the one-to-one interviews were in a private environment I was satisfied that the interview participants were given the opportunity to share further insight into resilience if they wished.

The participants were not sent any of the results of the study, including their individual resilience scale scores until the end of the study. Some researchers check their findings with the participants to inform the final data analysis, described as '*member checking or validation'* by Braun and Clarke (2013:282). A decision was taken for this study to withhold all data from the participants to avoid any potential influence on how they responded during the second phase of data collection. All results and a final report will be sent to the participants at the conclusion of the Doctorate of Education. Any future publication of the research study will preserve the anonymity of the participants.

6.4 Addressing the aims of the study and research questions

The aims of this research study were:

1. To explore what the concept of resilience meant to student midwives.
2. To ascertain the role that resilience might play for student midwives and whether it developed or not during the first 18 months of their midwifery programme.

The research questions were developed from the aims and then appropriate data collection tools selected. Considerable thought was given to ensuring the data collection tools selected were fit for purpose in terms of being able to collect data that would meet the aims and answer the research questions.

The decision to conduct a case study using different methods of data collection was taken, as it was felt that this was the most appropriate approach to address the research questions of the study.

The two overarching research questions for this study were:

1. How do student midwives recount their understanding of resilience in relation to the midwifery undergraduate programme?

2. To what extent is the development of resilience in the first 18 months of a three-year undergraduate midwifery programme a factor in a student's ability to navigate the undergraduate midwifery programme?

The study's research sub-questions were:

(a) What characteristics are evident in student midwives who describe themselves as resilient?

(b) What strategies do students adopt who describe themselves as resilient?

Table 13 demonstrates how the research questions have been addressed using the True Resilience Scale© and presents the themes that emerged from the qualitative data gained from the focus groups

and one-to-one interviews. The use of more than one method was to enhance the validity of the case study.

How the research questions in this study were addressed	
Results from the True Resilience Scale©	2. To what extent is the development of resilience in the first 18 months of a three-year undergraduate midwifery programme a factor in a student's ability to complete the undergraduate midwifery programme?
Themes from the qualitative data:	
1. The concept of resilience for student midwife practice	2. To what extent is the development of resilience in the first 18 months of a three-year undergraduate midwifery programme a factor in a student's ability to complete the undergraduate midwifery programme? (b) What strategies do students adopt who describe themselves as resilient?
2. The characteristics of the resilient student midwife	1. How do student midwives recount their understanding of resilience in relation to the midwifery undergraduate programme? (a) What characteristics are evident in student midwives who describe themselves as resilient? (b) What strategies do students adopt who describe themselves as resilient?
3. Opportunities and threats to resilience in the student midwife	2. To what extent is the development of resilience in the first 18 months of a three-year undergraduate midwifery programme a factor in a student's ability to navigate the undergraduate midwifery programme?
4. Reliance and relationships with others	2. To what extent is the development of resilience in the first 18 months of a three-year undergraduate midwifery programme a factor in a student's ability to navigate the undergraduate midwifery programme?
5. Resilience, the student midwife and childbearing women	1. How do student midwives recount their understanding of resilience in relation to the midwifery undergraduate programme?

Table 13: Demonstration that the research questions are addressed in the study

6.5 Limitations of the study

The conclusions of this study have to be considered in relation to the limitations of the research. One of the limitations of the study is that it was restricted to one western HEI in the East Midlands region of England. It would have been helpful to work with other groups of student midwives in one or more HEIs, but time constraints prohibited this.

At the commencement of the research, the study population was limited to 25 members of a single cohort of student midwives, which reduced to 18 by the conclusion. It could be suggested that this investigation was limited in terms of the size of sample within the institution. However, the smaller sample was better suited for qualitative analysis. Whilst it is suggested that the findings could be transferable, further research with a larger cohort from a range of institutions could provide additional validity to the findings.

Two of the research tools, i.e. the focus group and one-to-one interview questions were developed by myself and reflected my thoughts and ideas about the issues for this study of resilience. The design of the study could have been developed differently; for example, by including personal tutors of the students. The views of the midwives who supported the student midwives in clinical practice could also have provided useful insights into resilience. Time constraints prohibited an extension of the study; however, the individual research tools did align to the research questions and some useful insights were gained. Nevertheless, the study does present an important view of resilience from student midwives' perspectives and implications for them as learners.

6.6 Summary of recommendations proposed from this study

1. Midwifery curriculum teams should adopt the conceptual model of student midwife resilience. The use of the model will enable strategies to be developed, which for the first time are tailored specifically to the student midwife.

2. Using Tinto's (1975) adapted framework, midwifery programme teams should consider how integration into the midwifery profession is promoted and monitored. By applying Tinto's work to a midwifery programme, it could be suggested that the academic and social aspects of the programme as well as what the institution itself has to offer, could be made clearer for the student midwife and given value.

3. The Wagnild and Young's (2015) True Resilience Scale© could be used as a tool for student midwives to determine their level of resilience throughout the programme and to act as a trigger to access support and help as required.

4. Specific feedback for the results of the True Resilience Scale© scores, tailored for student midwives, should be created in order for the advice to them to be meaningful for their on-going development of resilience in midwifery practice.

5. Further research is recommended with a greater range of students across a number of HEIs and the individuals who support student midwives throughout the programme, to assess their views on the concept and significance of resilience in midwifery practice.

6. Midwifery lecturers should challenge the current resilience discourse through adoption of the RCM's (2016) '*Caring for*

You' strategy within the midwifery curriculum and ensure it is being fully applied to student midwives in midwifery clinical placements.

6.7 Conclusion

This study has been the first of its kind to enhance the understanding of the concept of resilience for student midwives. A key contribution of this study has been the development of a conceptual model of resilience specifically for student midwives. Four essential components are proposed for student midwives to be resilient and develop resilience further, namely: reactability, reflection and reflexivity, passion for midwifery and relationship with significant others. An individual being successfully integrated into the profession appears to safeguard student midwives when they encounter challenging or distressing situations. The ability to understand what has occurred in the clinical environment using a process of reflection also seems key to the student being able to learn from the experience and move on psychologically.

Increasingly the literature is discussing specific interventions that can promote resilience. Whilst in this study the students were clear that resilience could not be taught, it concludes that a number of resilience promoters strengthen resilience, which are reflected in the conceptual model. The conceptual model advances the discussion about the place of resilience in student midwifery practice and suggests that providing training programmes is not the solution.

The findings of the study could help students and academics working in the higher education sector to reconsider the definition of resilience and how it can be promoted in the midwifery undergraduate curriculum.

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List of appendices

Appendix 1: Key research papers included in the literature review

Author(s)	**Ahern et al (2006)**
Aim	To evaluate the use of resilience instruments with adolescents in terms of appropriateness and psychometric properties.
Setting and sample	Desktop. 6 psychometric surveys. All surveys were quantitative. Range of participants within the surveys 59-810. Target populations undergraduates, general and clinical populations. Mixed ethnic groups. Mostly females.
Design	Flow diagram provided. Clear inclusion and exclusion criteria. Exclusion – no original data, not measuring resilience, did not include items of the instrument, paper could not be found.
Findings / results	For the purposes of this study the Wagnild and Young True Resilience Scale© was of particular interest. Reliability – coefficient alpha 0.91. Item to item correlation ranged from .37 to .75 (majority between .50 and .70. $p \leq .001$).
Author(s)	**Carolan & Kruger (2011)**
Aim	To gain a deeper understanding of students concerns and it was intended as a first step to providing more meaningful student support.
Setting and sample	First year midwifery students. One Australian university.
Design	Basic demographic questionnaire to include age, income, living arrangements and numbers of children. A reflection to an open text question.
Author(s)	**Carolan-Olah et al (2014)**
Aim	To explore the experiences of final year Bachelor of Midwifery students.

Setting and sample	10 completing midwifery students.
Design	Qualitative approach informed by interpretative phenomenological analysis (IPA). In-depth interviews and reflected on their experience their three-year course.
Findings / results	Demographics – participants were generally aged over 35 years, worked 16 hours or less , most had children 4 main themes: 1: Challenging start. 2: Coming to terms with course requirements. 3: Developing strategies. 4: Overall satisfaction with the course. Participants considered their individual strengths & determinants helped them to negotiate the many challenges they encounter during the course.
Author(s)	**Cohn et al (2009)**
Aim	To assess the broaden-build- theory that positive emotions help people to build lasting resources.
Setting and sample	120 randomly selected from eligible respondents 1st or 2nd year University students recruited via a newspaper. Offered $100 for participation. More than 18 years of age with a score of less than 24 on a depression scale.
Design	Completed questionnaires in a laboratory. Used a computer validated diary method on website every evening for 28 days and submitted emotion reports using a modified Emotions Scale (Developed by Fredrickson et al 2003).
Findings / results	Positive emotions predicted increases in both resilience and life satisfaction. Average and stable emotions in participants showed a growth in resources even when on days they had a lot of negative emotions.
Author(s)	**Cope et al (2016)**
Aim	To understand why nurses make the choice to remain in the nursing workforce. To identify the qualities of resilience as resistance.
Setting and sample	9 nurses. 3 from interim and residential aged care, 3 from the academic setting, 3 from management. English speakers. Registered with Nurses and Midwives Board of Western Australia with more than 5 years experience in the Western Australia healthcare environment. Small but sample represented inclusion criteria and theoretical saturation reached.

Design	Qualitative portraiture methodology (Lawrence-Lightfoot, 1983). ('Why' nurses remain in the workplace often described as awful). Methodology aims to unearth goodness and highlight successes. Field notes, memos, gesture drawings (brief narratives) and interviews.
Findings / results	Resilience seen as a resistance to the new managerialism, where workplace practices does not value the human resource. Gains power to overcome challenges, negotiate conflicts and remain working. Nurses 'worldview' gained.
Author(s)	**Crombie et al (2013)**
Aim	To explore the factors that affect attrition and completion rates of second year adult nurse students.
Setting and sample	2 large London NHS trusts and their partner HEI. Self-selected 50 second years.
Design	Ethnographic care study. Mixed -method: Document review, Non-participant observation, Focus groups, Interviews.
Findings / results	Numbers of actors impacted retention including: student identity, the organisation, fostering resilience, clinical support, the HEI. Most significant effect of mentors and the practice setting. Contradicts other literature as to the most significant factor being the clinical placement experiences affecting the decision to remain or leave the programme.
Author(s)	**Crowther et al (2016)**
Aim	To explore concepts of sustainability and resilience that is currently being discussed in the workforce literature.
Setting and sample	Used primary midwifery research from UK and New Zealand. Compare, contrasted and explored concepts of sustainability and resilience.
Design	Discussion paper.
Findings / results	Recognised differences in model of maternity care between UK and new Zealand. Resilience and sustainability are overlapping themes from the studies reviewed. Evidence provides what is required to sustain healthy resilient practice. Four common themes: Self-determination, ability to self care, cultivation of relationship's both professionally and with

	women and families and passion, joy and love for midwifery.
Author(s)	**Curtis et al (2012)**
Aim	To explore student nurses experience of socialisation in 21st century compassionate practice. To consider the concerns that student had about providing compassionate practice.
Setting and sample	University north of England. 19 individual, in-depth interviews. Each participant interviewed once. 5 nursing lecturers interviewed. Took place on campus
Design	Grounded theory informed by symbolic interactionism.
Findings / results	Students felt vulnerable to dissonance between professional ideals and the reality of clinical practice. Felt uncertainty about future role and opportunity to adopt compassionate practice. Socialisation into compassionate practice is compromised with reality of practice. Fostering resilience was recommended.
Author(s)	**Davydov et al (2010)**
Aim	To collate and classify available resilience research using a multi-level biopsychosocial model. To reorganise knowledge into a unitary concept.
Setting and sample	Theoretical paper. Literature review.
Design	Categorisation, formation of table.
Findings / results	Construct reconceptualises health disturbances in terms of resilience deficiency (poor protection quality) and defect (health-promotion or harm-reduction), utilising, alternative frameworks (immune deficiency, and defective somatic health protection systems).
Author	**Fredrickson (2004)**
Aim	To provide the latest empirical evidence supporting the broaden and build theory and draw out implications the theory holds for optimising health and well-being.

Setting and sample	Literature review
Design	N/A
Findings/results	The broaden and build theory describes the from and function of a subset of positive emotions including joy, interest, contentment and love. A key proposition is that positive emotions broaden an individual's momentary though-action repertoire. The broadened mindsets arising from these positive emotions are contrasted to the narrowed mindsets sparked by negative emotions. Positive emotions promote discovery of novel and creative actions, ideas and social bonds, which in turn build that individual's personal resources, ranging from physical and intellectual resources, to social and psychological resources.
Author(s)	**Garcia-Dia et al (2013)**
Aim	To systematically review the concept of resilience historically, its attributes, its antecedents and the consequences of having the trait
Setting and sample	Used the Walker and Avant method to describe the cases. Used a concept map to present the interrelationship between the attributes, antecedents and consequences.
Design	Integrated review of the literature
Findings / results	Resilience is a relevant concept to patients and caregivers. Individuals have personal traits, protective factors and experiences that are gained throughout life to build up resilience.
Author(s)	**Grant & Kinman (2012)**
Aim	Paper that summarises research on interventions to promote resilience
Setting and sample	N/A
Design	N/A
Findings / results	Key predictors of resilience are emotional resilience and associated competencies of reflective ability, aspects of empathy, social confidence. Students need an internal 'tool-box' of strategies.

Author(s)	**Grant & Kinman (2014)**
Aim	To provide an overview of the research on emotional resilience for healthcare professionals
Setting and sample	Strategy not identified
Design	Literature review
Findings / results	Emotional resiliency is defined by Grant and Kinman as emotional literacy, reflective ability, empathy and social competence. Importance of developing an emotional curriculum. Educators need to prepare students for the realities of healthcare work and develop assertiveness to challenge workplaces that do not advocate well-being and seek support as required.
Author(s)	**Green & Baird (2009)**
Aim	To explore the retention and attrition of pre-registration student midwives.
Setting and sample	36 questionnaires to students who had left the programme. Purposive sample of 16 students formed two separate focus groups. University South-West England.
Design	An explorative, comparative design. Quantitative and qualitative methods.
Findings / results	Midwifery attracts motivated students. Motivation needs to be nurtured as the programme is emotionally and theoretically demanding. Realistic expectation of the programme, the 'lived' experience created anxiety and tension. Mentorship and support are key. Uniqueness of the midwifery programme.
Author(s)	**Hunter (2004)**
Aim	To explore how a range of midwives experienced and managed emotion in their work
Setting and sample	Self-selected convenience sample of 27 student midwives in first and final year of 18-month and three-year pre-registration midwifery programme. Purposive sample of 29 midwives, of a range of grades and experience in one local NHS Trust. South Wales.

Design	Qualitative, ethnographic study. Three phases of data collection focus groups, observations and interviews.
Findings / results	Emotional work found in conflicting ideologies of midwifery practice; particularly evident in students and newly qualified midwives. Education and supervision strategies may support change. However, radical solutions may be required to address the situation.
Author(s)	**Hunter and Warren (2013)**
Aim	1. To explore clinical midwives' understanding and experience of resilience 2. To identify personal, professional and contextual factors to contribute or act as barriers to resilience 3. To explore how resilience of student and newly qualified midwives might be enhanced.
Setting and sample	Funded by the Royal College of Midwives. Midwives who self-identified as resilient with greater than 15 years experience of hands-on clinical experience. Recruited through an advert placed in the RCM Midwives' magazine. A closed online discussion group. 11 midwives.
Design	Findings were discussed with a panel of experts in the field to refine modelling of the concept.
Findings / results	4 themes: Challenges to resilience, Managing and coping, Self awareness, Building resilience. Implications: Concept resonated with participants, Needs to be proactively fostered in the initial and continuing education of midwives, Further research is warranted with midwives at different stages of their careers.
Author(s)	**Johnson et al (2012)**
Aim	Authors propose that the conceptual orientation of professional identity is a logical consequence of self-concept. A measurable set of concepts can be manipulated to improve student and registered nurses retention.
Setting and sample	Present a professional identity pathway
Design	Theoretical discussion paper. Initial literature review.
Findings / results	Nurses' identities develop throughout their lifetimes, prior to commencing the nursing programme. Educational experiences subject the nursing student to further socialisation to the shared values and attributes of the profession.

	Identity and self-concept not well-defined in the literature.
Author(s)	**Levett-Jones and Lathlean (2009)**
Aim	To explore nursing students' sense of belongingness when undertaking clinical placements. To locate the professional and practical implications of the research within an Ascent to Competence conceptual framework.
Setting and sample	3rd year pre-registration nursing students – 362 quantitative phase, 18 in qualitative phase. 3 universities (2 in Australia, 1 in England).
Design	Mixed –methods, cross national, multi-site case study.
Findings / results	Primary aim of clinical practice is to gain competence, achievement of this goal is affected by a wide range of individual, interpersonal, contextual and organisational factors. The authors framework demonstrates that students' progress towards attainment of competence is only possible when needs of safety, security, belongingness, healthy self-concept and learning have been met.
Author(s)	**Mayer et al (2004)**
Aim	To review the literature on emotional intelligence.
Setting and sample	Literature review.
Design	N/A
Findings / results	Provide a clear definition of EI of their own. The priorities for research are: Learning more about what EI predicts, Understanding of how EI relates to other intelligences and personality traits, Understanding the process of EI, Determining whether teaching emotional knowledge has a desirable effect on behavioural outcomes and might change EI itself, Expanding EI measurement to a wider range of age groups to better understand its developmental course.

Author(s)	**McAllister and McKinnon (2009)**
Aim	To review the literature on resilience
Setting and sample	School of Health and Sport Sciences. Australia.
Design	Literature search strategy not included.
Findings / results	Resilience theory should be part of educational content and workplace culture to promote reflection and application. Students need to develop strength, focus and endurance for the workplace.
Author(s)	**McDonald et al (2012)**
Aim	To use a work-based educational intervention to support the development of personal resilience in nurses and midwives.
Setting and sample	14 nurses and midwives in 2 cycles. Volunteers. Variety of qualification and experience. Working at the Australian hospital 18 months-22 years. 11 Australian borne, three migrated from Europe or Asia.
Design	6 monthly workshops forming a participatory learning group.
Findings / results	Post intervention participants reported positive personal and professional outcomes including self-confidence, self-awareness, communication and conflict resolution skills.
Author(s)	**McGillivray and Pidgeon (2015)**
Aim	To examine the attributes of resilient university students by comparing the differences between high and low resilient students on levels of reported psychological distress, sleep, disturbances and mindfulness.
Setting and sample	89 university students. Age range 18-57 years.
Design	3 Measures: Wagnild and Young's resilience scale (RS14), The Depression Anxiety stress scale, Freiburg Mindfulness Inventory.

	Combined with a single online package of questionnaires including an explanatory statement and general demographics section. Correlation analyses conducted between the variables of resilience, psychological distress, sleep disturbances and mindfulness.
Findings / results	Students with resilience reported significantly lower levels of psychological distress, higher levels of mindfulness compared to students with low resilience no significant differences reported in regard to sleep disturbances.
Author(s)	**McGowan and Murray (2016)**
Aim	To explore the concepts of resilience and hardiness in nursing and midwifery students. To identify educational interventions to promote resilience.
Setting and sample	Databases used; Medline, CINAHL, Embase, PsycINFO, Maternity and Infant care databases. January 1980-Febraury 2015.
Design	Integrative literature review. 8 quantitative studies included.
Findings / results	Resilience literature in nursing and midwifery education scarce. Weak evidence that resilience that resilience and hardiness is associated with slightly improved academic performance and decreased burn-out. Studies are heterogeneous in design and poor methodological quality. Greater theoretical understanding of resilience in nursing and midwifery students is needed.
Author(s)	**Pooley and Cohen (2010)**
Aim	To examine four research studies within four different contexts to understand the concept of resilience within a broader systems view. It considers resilience is developed in individuals and the contexts in which resilience is supported.
Setting and sample	4 separate qualitative and quantitative research studies namely: adolescents in school, women and domestic violence, children in separated families and students adjusting to university.
Design	Review of four studies.

Findings / results	Support for examining resilience in different contexts. Highlights how context interacts with the processes of resilience. Variables change over time, understanding of these is required to understand the dynamic of resilience.
Author(s)	**Pryjmachuk et al (2009)**
Aim	To identify the factors that have an impact on student complete rates in a pre-registration programme.
Setting and sample	Routinely-collected demographic and completion dates on four cohorts of nursing students studying in a large university in England.
Design	Retrospective cohort study.
Findings / results	Older students (over 25 years) were more likely to complete the programme. Students with the minimum education qualifications on entry were less likely to complete. Child branch had a higher attrition rate. In both black and ethnic students. Particular healthcare organisations can influence completion rates.
Author(s)	**Reyes et al (2015)**
Aim	1. To analyse and synthesise empirical and theoretical reports on resilience in nursing education. 2. To consider the implications of the review for nursing education practice and research.
Setting and sample	Databases: CINAHL, Scopus, Educational Information Resources Centre,Psycho INFO, Pubmed and ProQuest.
Design	Integrative review using Whittemore's and Knafl's method to analyse and synthesise the literature on resilience.
Findings / results	Three main themes emerged: 1. Resilience is important in nursing education. 2. Resilience is conceptualised as either as a trait or a process. 3. Resilience is related to protective factors A summary of all the studies reviewed was provided. All studies recommended further study with larger cohorts. Researchers are aware of the importance of resilience for nursing education but are yet to integrate it.

Author(s)	**Roxburgh (2014)**
Aim	To explore Undergraduate nurses' perceptions of two models of practice learning (namely a hub and spoke model and a rotational model).
Setting and sample	10 undergraduate nursing student at the end of the second year of the programme. Previous study had determined that these students in year 1 that the hub and spoke model improved belongingness, continuity and quality of placement learning.
Design	Focus group interviews
Findings / results	Students reported that year 1 had raised their faith that they could cope with clinical and academic demands. As a result they were better prepared for year 2 hub and spokes. Conclusions: these students displayed traits of resilience, continued belongingness, self-confidence, and orientation to learning in practice in the hub and spoke model. First year students require structured and supportive learning environment to enable resilience in subsequent years.
Author(s)	**Rutter (2006)**
Aim	To review the concept of resilience and its definitions.
Setting and sample	Discussion paper and review of research.
Design	Literature review.
Findings / results	Five main implications from research to date: 1.Resistance to hazards may derive from controlled exposure to risk (rather than its avoidance) 2.Resistance may derive from traits or circumstances that are without major effects in the absence of the relevant environmental hazards 3. Resistance may derive from physiological or psychological coping processes rather than external risk or protective factors 4. Delayed recovery may derive from 'turning point' experiences in adult life

	5. Resilience may be constrained by biological programming or damaging effects of stress/adversity on neural structures.
Author(s)	**Sidebotham et al (2015)**
Aim	To examine the expectations and experiences of second and third year student midwives enrolled on a Bachelor of Midwifery programme to identify and barriers and enablers to success.
Setting and sample	SE Queensland. 56 students. 16 participated in two year 2 focus groups.
Design	Descriptive, explorative, qualitative design
Findings / results	Students link theory and practice together and increased their perception of their ability better when they have experienced continuity of care schemes with early exposure to practice. Programmes that embedded women-centred approaches affected the students' sense of identity, purpose, resourcefulness and capability.
Author(s)	**The Royal College of Midwives (2016)**
Aim	To investigate why midwives leave the profession.
Setting and sample	2719 responses 30.8% of responses were from midwives who have had left midwifery in the previous 2 years, 69.2% of responses midwives were intending to leave in the next 2 years.
Design	Online survey. 8-18 August 2016 Ent by email to RCM members. Promoted on social media streams. Asked midwives to complete the survey who had left the profession or were intending to leave in the next 2 years.
Findings / results	Greatest reasons for leaving were staff workload and not having enough time to give women and families high quality care.
Author(s)	**The Royal College of Midwives (2011)**
Aim	To investigate how changes in policy in health service and HEIs has affected student midwives experiences.

Setting and sample	Survey sent to 4600 midwives (905 of student midwives) 763 (22%) student midwives responded who were members of the RCM. Majority were 1st and 2nd years.
Design	Follow up survey last undertaken in 2004 On-line descriptive study 58 items concerning four areas: 1. Demographic profile 2. Experience of midwifery education and clinical practice 3. Views on student memberships services 4. Networking behaviour of student midwives
Findings/results	A substantial number of students did not answer the questions set. Many highlighted such excellent personal tutor who cares and helps you achieve your potential. Some very negative comments rude mentors, mentors that destroy their confidence, negativity amongst the professions.
Author(s)	**Thomas and Revell (2016)**
Aim	To explore the state of knowledge on resilience in nursing students
Setting and sample	Databases used; CINAHL, ERIC, PsychoINFO. Whitmore and Knafl's integrative approach was used to conduct the methodological review. 1990-2014. Search terms given.
Design	Integrative review.
Findings / results	9 papers, all but 1 utilised definitions of resilience from psychology. Factors that affect resilience were grouped into three themes namely: support, time and empowerment. Strategies to develop resilience were discussed in three of the articles but methods and findings were different. Review reviews what is known about resilience in nursing students and what contributes to development of the trait. Support from family, friends and the Faculty is key.
Author(s)	**Tugade & Fredrickson (2004).**
Aim	To address the deficit in empirical evidence for the 'broaden & build' theory.
Setting and sample	Multi method approach in 3 studies to predict if positive people use positive emotions to bounce back.

Design	All 3 studies involved undergraduates at the University of Michigan.
Findings / results	Mediational analysis indicated that the experience of positive emotions might have contributed to the ability to achieve efficient emotion regulation, as demonstrated by accelerated cardiovascular recovery from negative emotional arousal (Studies 1&2) 7 by finding positive meaning in negative circumstances (Study 3).
Author(s)	**Ungar, M (2008)**
Aim	To explore the cultural and contextual understanding of resilience to interventions with at-risk populations.
Setting and sample	14 site mixed methods study.
Design	1500 youths.
Findings / results	They are global as cultural and contextual aspects that contribute to resilience. Exert different amounts of influence. Aspects of children's lives that contribute to resilience as related to one another in terms of context and culture. Tensions are resolved that reflect specific relationship between the aspects of resilience.

Appendix 2: Participant information sheet

(Logo of the University)

School of Health Sciences

Division of Midwifery

Title of Project:

Student Midwives 'Navigating' the Midwifery Undergraduate Programme- is resilience the key?

Name of researcher: Jacqui Williams, Associate Professor in Midwifery

Student Midwives' Participant Information Sheet

I would like to invite you to take part in a student midwife research study. Before you decide whether to take part, it is important for you to understand why the research is being done and what will be involved. Please take time to read the following information carefully to decide whether you want to take part or not and discuss it with friends and relatives if you wish to. Please do not hesitate to ask me if there is anything that is not clear, or if you would like more information. Thank you for reading this information sheet.

Background to the study

Recent research has considered whether resilience is the key to being a successful midwife and remaining within the midwifery profession (Hunter & Warren, 2013). However, there is little literature to date that has explored the concept of resilience amongst student midwives.

This study will explore what resilience means to you as a student midwife and the role that resilience might play in supporting you to cope with the first 18 months of the Midwifery Programme. The study is also interested in whether resilience develops or not in the Programme.

I am studying for a Doctorate in Education with the Open University, UK, and this study is part of that programme. The research will be undertaken within the Division of Midwifery, School of Health Sciences at the University of Nottingham.

What does the study involve?

All midwifery students in the September 2015 cohort will be asked to take part in this study. It involves the completion of a resilience survey tool on three occasions namely: at the commencement of your programme, after nine months, and at 18 months. The Resilience

Scale tool uses a 7-point scale ranging from 1 (disagree) through to 7 (agree). The survey tool should take a maximum of 15 minutes to complete. The reason it will be completed three times is to allow comparison of the results over half of your midwifery programme. General biographical details about yourself and your assessment grades will also be collected.

You will also be asked to take part in a focus group and an individual interview at the 9 month and 18 month stages. Each focus group and interview should last no longer than one hour.

Arrangements will be made for the study activities to take place on campus on the days that you would be coming to the university for your theoretical sessions.

Why have I been chosen?

The study requires first year students to be involved at the commencement of their programme. Within the time constraints of my doctoral study, the midwifery students who commence their programme in September 2015 is the cohort that can be followed for an eighteen-month period.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. You are also free to withdraw from the study at any time without giving a reason.

What will I be asked to do?

You will be asked to complete a resilience survey tool on three occasions during the first eighteen months of your programme. You will also be asked to take part in a focus group, facilitated by myself as the researcher, to discuss what you understand by the term resilience and whether you consider it is key to you successfully completing the Midwifery Programme. Some of the study participants will be invited to have a one-one interview with myself to explore the issues raised about the concept of resilience in the focus groups. Both the interviews and focus groups will be audio recorded using a digital recording device. You are free to withdraw at any time without giving any reason and you can ask to withdraw your data up until March 2017. After this time the anonymised data will be entered for full analysis.

Are there any disadvantages or risks for me if I take part?

There should not be any risks to you by taking part in this study.

There is a possibility that you may get upset if you recall particular experiences that have happened to you. There would be no adverse consequences for yourself and the Midwifery Programme whether you choose to decide to take part in the study or not.

What if something goes wrong?

If you have a complaint about the treatment you receive or anything else to do with the study, you can initially approach myself, Jacqui Williams, the researcher and/or my Supervisor, Professor Judith Lathlean.

If I cannot resolve the issue in this way the [redacted] has a robust process for handling complaints by students. Please go to the following link: (link of the university's complaints department)

This process will be adhered to during this study in the event of you wanting to make a complaint.

If I take l take part in this study will details about me be kept confidential?

In accordance with the Data Protection Act I need to obtain your permission to allow restricted access to the information collected about you in the course of the study. All information collected about you is necessary for carrying out the study and will be stored on a database that will is password protected and strictly confidential. As this study is part of a doctoral study the data will be released to a third party but will be anonymised and cannot be traced to you. Any information about you, which leaves the Division of Midwifery, will have your name removed so that you cannot be recognised from it.

What will happen to the results of the research study and who is organising and funding the research?

The research is the focus of my doctoral study and I am organising the research under the supervision of two supervisors appointed by the Open University. Any costs will be borne by myself.

Who has reviewed the study?
This study has been reviewed and given favourable opinion by the [redacted] and the Human Research Ethics Committee of the Open University.

Contact for Further Information

A copy of this Information Sheet and the signed consent will be given to you for future reference.

Appendix 3: Participant consent form

(Logo of University)

School of Health Sciences

Division of Midwifery

Participant consent form

Title: Student Midwives 'Navigating' the Midwifery Undergraduate Programme – is resilience the key?

I, (print name …. ……) agree to take part in this research project.

Please initial boxes

1. I confirm that I have had the purposes of the research project explained to me. I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and I have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, up until March 2017, the anonymised data are entered for full analysis and without my midwifery programme or legal rights being affected. ☐
3. I have been assured that my confidentiality will be protected as specified in the information leaflet. ☐
4. I understand that personal information collected in this study will be confidential, anonymous and protected. ☐
5. I understand that if there is a cause for concern, or unprofessional/illegal practice is disclosed I can refer the matter to the University of X complaints process: (link to University's complaints and grievance procedure) ☐

6. I agree that the information that I provide can be used for educational or research purposes, including publication. ☐

7. I give permission for information, including the use of quotations, collected in the audio recording of the group discussion, or interview, to be used in any presentation of the research findings with the understanding that my anonymity will be assured. ☐

8. I understand that if I have any concerns or difficulties I can contact:

1. Name of researcher: Jacqui Williams
2. Supervisor of Research Study: Professor Judith Lathlean
3. The Complaints Process offered by the School of Health Sciences, The University of X.

Appendix 4: Wagnild and Young's (2015) True Resilience Scale©

No	Question
1	If something is worth starting, I'm going to finish it
2	I depend on myself to find a way of surviving
3	I stay true to myself even when I'm afraid to do so
4	I know why I'm on this earth
5	My deeply held values guide my choices
6	Every day I do something that is meaningful to me
7	I can see most situations from different points of view
8	I'm honest with myself when something is wrong with me
9	In a time of trouble, I figure out what needs to be done
10	Even if don't feel like it, I do what I need to do.
11	Looking back at my life, I feel satisfied
12	I'm not upset for too long when life doesn't go my way
13	I rely on myself to do what is right for me
14	I am determined even if the odds are against me
15	I am excited about the plans I have
16	I remain calm under pressure
17	I make decisions that are consistent with my beliefs
18	I often tell myself " I can do this"
19	I can find something positive in whatever happens
20	I see an obstacle as a challenge to overcome
21	I can say what I am good at
22	I rely on my sense of humour to improve my outlook
23	I take responsibility for my decisions
24	Disappointment doesn't stop me from trying again
25	I know what's most important to me and this knowledge guides my life.

Appendix 5: Revised question schedule

May 2016 First focus group question schedule:
• What is your understanding of the term resilience? • What personal attributes would you identify in someone who describes themselves as resilient? • What would you say the term resilience means for a student midwife on the midwifery programme? • Can you give some examples of where you have observed/recognised examples of resilience whilst being on the midwifery programme? • The term 'midwife's hat' has been used to describe what is done emotionally at the beginning of the shift and taken off at the end. In what ways can you identify with this analogy? • Do childbearing women need the midwife to be resilient themselves? Please explain your answer. • What would you say are the barriers to someone being resilient on the midwifery programme? • How could resilience be enhanced in student midwives, to prepare them for becoming registered midwives?
May 2016 - First one-one interview question schedule
• Would you describe yourself as being resilient? Yes/No If answers yes - What personal attributes would you say you have by describing yourself as resilient? - What particularly has had an impact on you so you can describe yourself as resilient? or If answers no

- What personal attributes would you say you lack by describing yourself as not resilient?

- What would you say are the barriers to you being resilient whilst on the midwifery programme?

- In the literature it has been suggested that an 'internal tool box' is required to be resilient. Would you be able to give any examples of that from your own experience?

- How could resilience be enhanced generally in student midwives for the midwifery programme and to prepare them for becoming registered midwives?

- In the focus group I was interested to hear you talking about …(cite the example) …could tell me/talk to me a bit more about this?

March 2017 - Second focus group question schedule:
Participants will be advised that the questions asked in the first focus group are being broadly used again.

- What is your current understanding of the term resilience?

- What personal attributes would you currently identify in someone who describes themselves as resilient?

- What would you say the term resilience means for a student midwife on the midwifery programme who has completed eighteen months of the programme?

- Can you give some recent examples of where you have observed/recognised examples of resilience whilst being on the midwifery programme?

- The term 'midwife's hat' has been used to describe what is done emotionally at the beginning of the shift and taken off at the end.

In what ways can you currently identify with this analogy?

- What would you say are the barriers to someone being resilient now they have completed 18 months of the programme?

- How could resilience be enhanced in student midwives, to prepare them for becoming registered midwives in eighteen months time?

March 2017- Second One-one interview question schedule

- Would you describe yourself as being resilient at the moment?

Yes/No

If answers yes

- What personal attributes would you say you have by describing yourself as resilient?
- What particularly has had an impact on you so you can describe yourself as resilient?

or

If answers no

- What personal attributes would you say you lack at the moment by describing yourself as not resilient?

- What would you say are the barriers to you being resilient at the moment?

- During your last one-to-one interview you talked about an 'internal tool box' which the literature says is required to be resilient. Would you be able to give any further examples of that from your own experience?

- Now that you have completed eighteen months on the programme, how could resilience be enhanced generally in student midwives for the midwifery programme and to prepare them for becoming registered midwives?

- In the focus group I was interested to hear you talking about …(cite the example) …could tell me/talk to me a bit more about this?

JW/6 May 2016

Appendix 6: Example of coding and themes

Group FG2 Friday 17 March 2017 08:30-09:30			
Text	Points of Interest/Code	Themes	Group interaction
JW: Thank you for coming back for the final focus group. So can I first ask what is your current understanding of the term resilience?			
14: Our ability to come back after a fall, I don't know, a difficult day.	Come back after a fall	Concept and definition of resilience	
JW: What sort of fall?			
14: Like failing your exam (JW:OK) or not having a good time on placement.	Failing an exam Poor time on placement	Characteristics of a resilient midwife	
JW: Current understanding of the term resilience for you 18 months in.			
14: Emotional resilience as well.	Emotional resilience	Concept and definition of resilience	
4: Carrying on, ability to carry on.	Ability to carry on	Characteristics of a resilient student midwife	
KG: Like being able to deal with stressful situations as well.	Deal with stressful situations	Characteristics of a resilient student midwife	
JW: Any sort of examples?			
4: I guess the module we've	Module	Opportunities and threats	Agreement

just had was emotionally challenging (All: Yeah)	Emotionally challenging		
9: And if someone discloses something emotional to you and how you deal with that, like stressful situations and things like that.	Emotional How you deal with it	Characteristics of a resilient student midwife	
14: So like how you seek support and deal with stressful situations (JW: Situations)	Seek support Deal with stressful situations	Characteristics of a resilient student midwife	
10: I was thinking like emergency situations on the labour ward and things like that.	Emergency situations	Opportunities and threats to resilience	
JW: OK			
7: I say resilience is remembering why you are doing something so instead of giving up thinking about why you are doing it in the first place to help you carry on.	Remembering why you are doing something Not giving up Carry on	Concept and definition of resilience Characteristics for a resilient student midwife	Agreement

Appendix 7: Pertinent questions for analysis of focus groups

- How closely did the group adhere to the issues presented for discussion?
- Why, how and when were related issues brought up?
- What statements seemed to evoke conflict?
- What were the contradictions in the discussion?
- What common experiences were expressed?
- Were alliances formed among group members?
- Was a particular member of viewpoint silenced?
- Was a particular view dominant?
- How did the group resolve disagreements?
- What topics produced consensus?
- What interests were being represented in the groups
- How were emotions handled?

Reference: Stevens, P.E. (1996:172) Focus Groups: Collecting Aggregate-Level Data to Understand Community Health Phenomena *Public Health Nursing* 13**(3)**:170-176

Appendix 8: Analysis of the study's focus group interaction using Stevens' (1996:172) questions

Question	Response
How closely did the group adhere to the issues presented for discussion?	The groups responded to the questions throughout.
Why, how and when were related issues brought up?	The groups kept to the topic and brought in related areas when they were using examples of their own largely from experience in clinical practice.
What statements seemed to evoke conflict?	All groups were amiable and I did not observe conflict per se. There were three students across the four focus groups who gave different views to the rest of the cohort. Two of these students tried to present an alternative view with the intention of expanding the topic and exploring it from different angles. There was on student, however, whose views were at odds with her group and the rest of the groups. She changed groups between the first and second session and were at odds with each group. Members of both groups did not try to change her views but seemed to accept them at face value and did not comment further.
What were the contradictions in the discussion?	None observed. Problem solving was noted when the groups were trying to come to consensus in respect of the question under consideration.
What common experiences were expressed?	These were evident throughout except for one participant whose views were not in alignment with the members of the group. Many examples from midwifery clinical practice were given reflecting what student midwives were experiencing during

	placement periods.
Were alliances formed among group members?	The group remained as separate contributing individuals contributing but worked together as a whole when they responded in agreement together.
Was a particular member of viewpoint silenced?	This was not observed. The one participant who had an alternative view did not receive lengthy responses from the other members. Also one participant who shared her current views of low resilience did not receive any response.
Was a particular view dominant?	All members of the group took turns and each group politely allowed each member to contribute. Two participants articulated ideas well in terms of expressing them in similes that warranted the use of their direct quotations. Some members of the group took longer to contribute than others but were engaged throughout and were demonstrating non verbal cues of engagement for example, nodding, smiling.
How did the group resolve disagreement?	This was not observed.
What topics produced consensus?	Consensus was seen throughout.
Whose interests were being represented in the group?	Those of student midwives and childbearing women. No one individual's interests were apparent. All group members were committed and passionate about the prospect of becoming midwives and midwifery practice.
How were emotions handled?	The group members were enthusiastic about being part of the focus groups. One member was very quiet in the second focus group meeting until a question was asked directly of her. Nevertheless, she was non verbally engaged throughout for

	example leaning forward, nodding. One group particularly found the process very cathartic in terms of what they were personally gaining from it. For example, the opportunity to reflect on what was happening in the programme in a constructive way. Where difficult or personal topics were shared there was verbal support from other members of the group and they indicated that they had had similar experiences.

I used the questions separately for each group and for each meeting but found that there were mostly similarities across all eight focus groups. Therefore, I chose to subsequently do my own systematic analysis of group interaction to gain a more detailed commentary. As a result I was able to develop some common themes across the groups in terms of their interaction.

Appendix 9: Example of the development of coding into five themes

Phases (based on Braun and Clarke, 2013)				
	Generating initial codes Systematically worked through transcriptions, identifying points of interest and codes	**Searching for themes** Some initial themes identified	Reviewing themes Reviewing all data from all sources	**Defining and naming themes** Refinement of themes and sub-themes

Transcript "Our ability to come back after a fall, I don't know, a difficult day" "Carrying on, .." "Like being able to deal with stressful situations"	Coming back after a fall or a difficult day Carrying on Dealing with	Traits and definition of resilience	Need to define resilience using key words but also consider as a broader concept.	**Theme 1**: **Concept and definition of resilience for these student midwives practice**

Transcript "...but you have to have the confidence to believe in yourself and go and do all these things and to move forward" "like I guess burnt out midwives and they are less passionate" "....by having a focus, by having a goal..." "I just think if you've got a good balance ....." "...I've compartmentalised everything which one I have to do first"	Having confidence Moving forward Burning out, Being less passionate Having a focus, a goal Having good balance to deal with anything Compartmentalising everything	Student midwife and resilience The reality of student midwife practice	Key features identified pertinent to student midwives. Sub themes to cover full range of features	**Theme 2: Characteristics of a resilient student midwife** Emotional awareness and intelligence - Having passion, balance and the ability to compartmentalise - Being flexible and adaptable

Transcript "Like failing your exam or not having a good time on placement" "Maybe after a situation you need a bit of time to reflect and then go back the next and say I really need to talk about what happened yesterday. Everyone reflects on it differently."	Failing exam Having poor experience on placement Time to reflect Everyone reflects on it differently.	Student midwife experiences – positive and negative	What might affect a student midwife's resilience? Major impact of the programme and personal life.	**Theme 3: Opportunities to promote and threats to hinder resilience in a student midwife**

Transcript "I think you can always learn from example …she still has that passion.."	Learning from example Mentor Qualified for years Having passion	Reliance and relationships with significant others Passing on knowledge	Passion to be a subtheme of student midwife characteristics Include range of others that had an impact on a student midwife's resilience	**Theme 4: Reliance and relationships with others**

Theme 5 "…I think [a midwife] shouldn't appear resilient, I think it should be so kinda natural, I think if you come and you're struggling and you're appearing resilient to the woman, they see you are coping with struggle…".	Not appearing resilient Struggling and yet appearing resilient to the woman [Resilience] rubbing off on women	Resiliency for midwifery practice	Need to be clear how this relates to women in their care. Importance to the student midwife.	**Theme 5: Resilience, the student midwife and the childbearing woman**

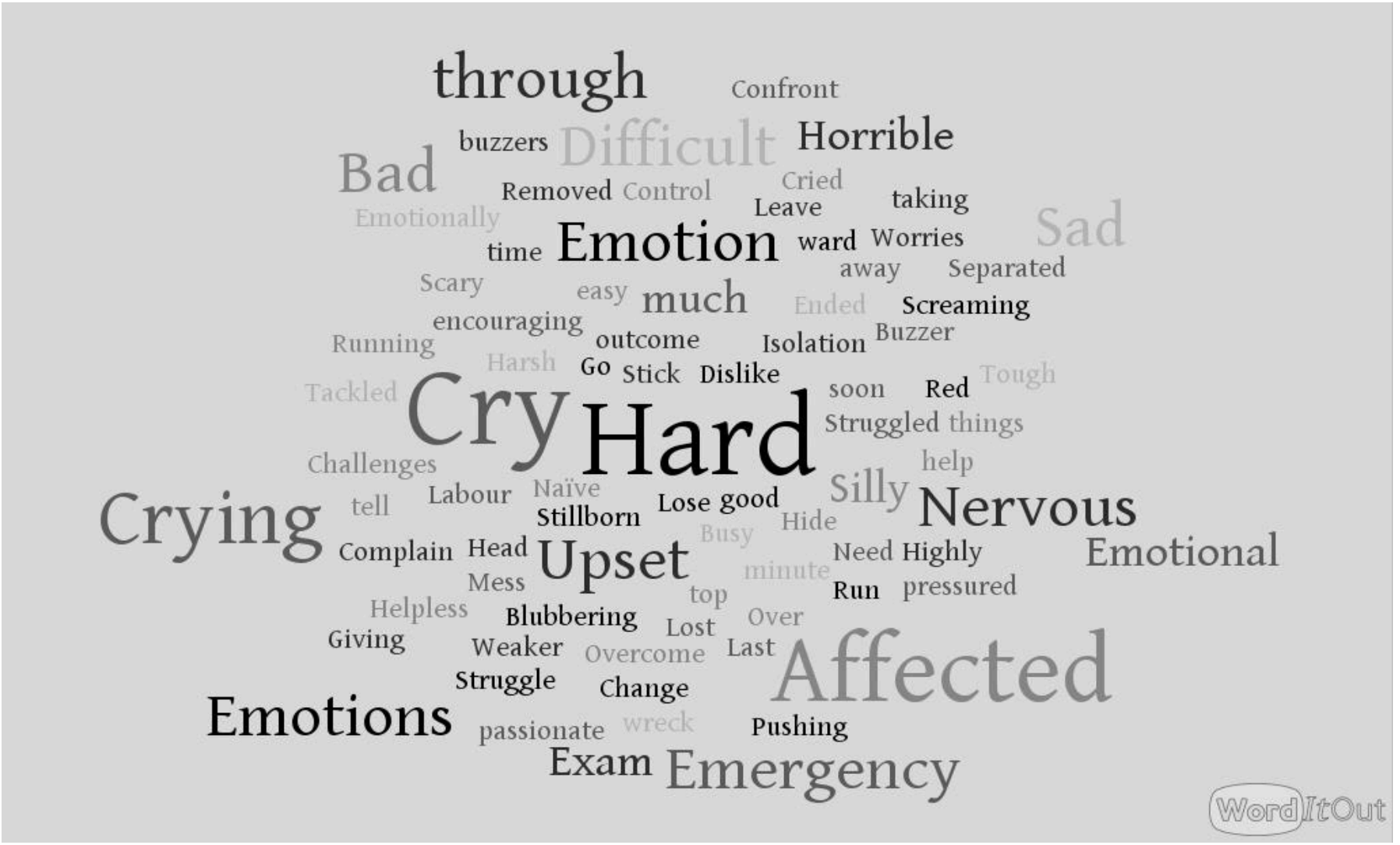
Producing the report of the analysis; selection of vivid, compelling examples
Examples used from across all focus groups and one-to-one interviews

Appendix 10: Relationship of research questions to the themes generated from the data

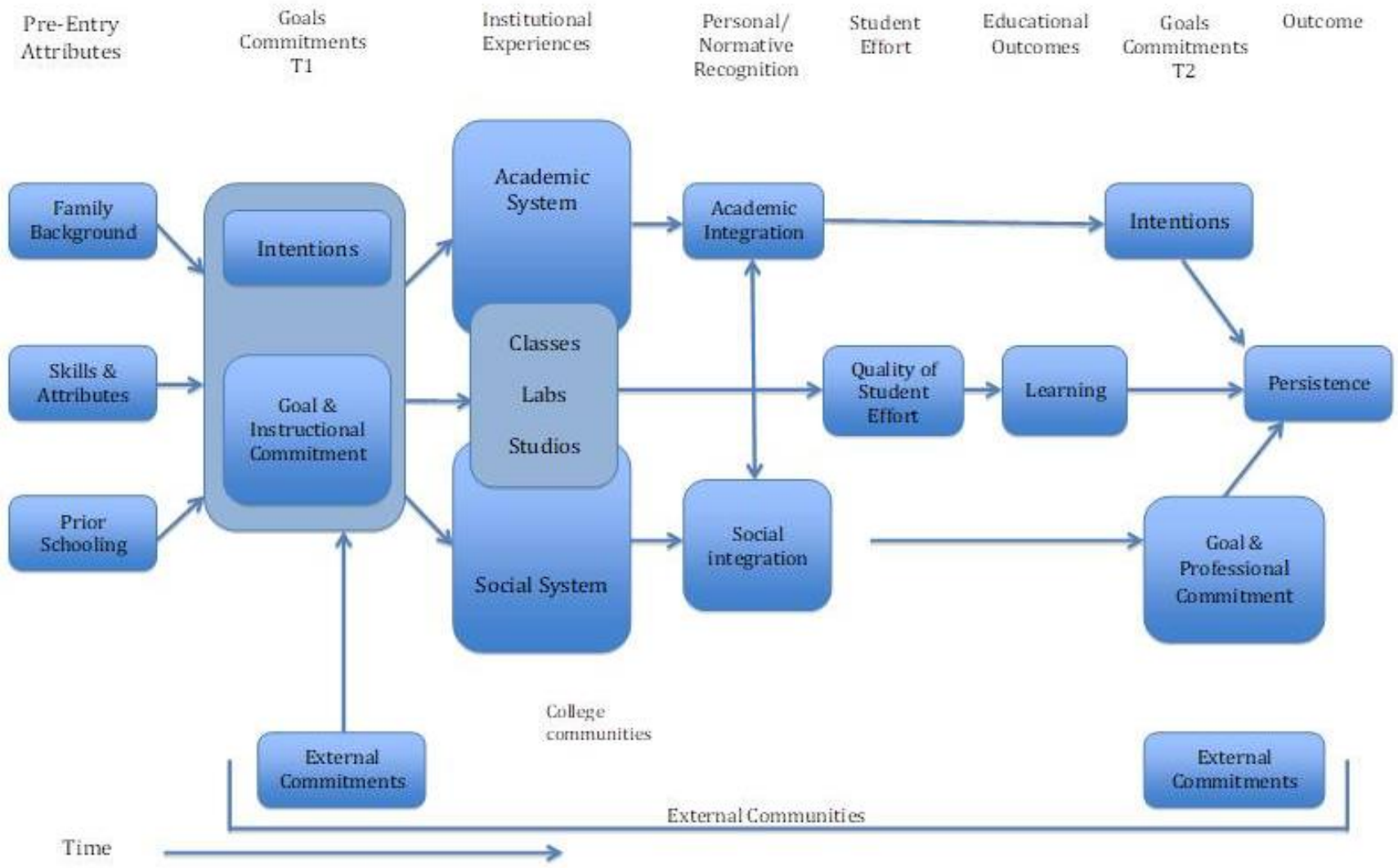
Overarching research questions	Theme 1: The concept of resilience for student midwife practice	Theme 2: The resilient student midwife	Theme 3: Opportunities and threats to resilience in the student midwife
1) What understanding do student midwives have of the concept of resilience?		X	
2) To what extent is the development of resilience in the first 18 months of a 3-year undergraduate midwifery programme a factor in a student's ability to cope with the programme?	X		X
Research sub questions			
a) How much does resilience develop or not during the first 18 months of a 3-year midwifery programme?		X	
b) What characteristics are evident in student midwives who describe themselves as resilient?	X	X	

Appendix 11: Word cloud example of positive words used in a focus group

Appendix 12: Word cloud example of negative words used in a focus group



Appendix 13: Tinto's revised model of student attrition (1997)



Appendix 14: Adapted from Tinto's revised model of student attrition (1997)